

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Make correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03549 40

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Baltimore.....
 City or town..... Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... E. Joppa Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

ALBERTA G.M. AKEHURST

3. (b) Social Security Number

4. Sex female	5. Color or race white	6.(a) Single, married, widowed, or divorced widowed	
6.(b) Name of husband or wife..... C. Edward Akehurst			
7. Birth date of deceased (mo., day, yr.) Nov. 13th, 1868		6.(c) If alive, give age..... years	
8. AGE: Years 79	Months 4	Days 18	If less than one day hrs. min.
9. Birthplace..... Harford County, Md. (Town, county, and state) at home			
10. Usual occupation.....			
11. Industry or business.....			
MOTHER	12. Name..... Geo. W. Martin		
	13. Birthplace..... Harford County, Md.		
	14. Maiden name..... Emma A. Pierce		
FATHER	15. Birthplace..... Baltimore County, Md.		

16. Informant..... D. Elmer Akehurst
 Address..... E. Joppa Rd., Fullerton P.O.
 17. burial Date thereof..... 4/4/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Camp Chapel
 Location..... Fullerton, Md.
 18. Funeral director..... Lassahn Funeral Home
 Address..... 7401 Belair Road
 19. 4/2/48 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 1st, 1948, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1948, to April 18, 1948, and that I last saw him alive on March 31, 1948.

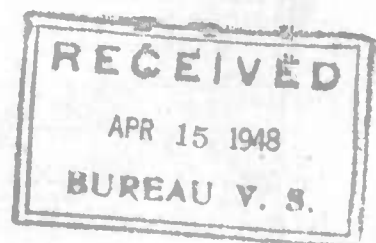
Immediate cause of death.....
 Due to..... myocardial infarction
 Due to..... Arterio-sclerosis
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... S. Elmer Akehurst
 Address..... 1401 Oriole Ave. Date signed 4/1/48
 M. D. or other



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03550

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
97 D St. Dr. Farber's office
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7529 Hallman ave
(If rural, give LOCATION)

3. (a) FULL NAME

Carlo Lewis Amisano

(Amisano)

3. (b) Social Security Number

218-01-8815

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Naomi D.

7. Birth date of deceased (mo., day, yr.) June 22/1900

8. AGE: Years 47 Months 9 Days 13 If less than one day
..... hrs. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Crate operator

11. Industry or business Berk Street Co.

12. Name Berly Amisano

13. Birthplace Italy

14. Maiden name Amisano

15. Birthplace Italy

16. Informant Mrs. Naomi Amisano

Address Sparrows Point, Md.

17. (Burial, cremation, or removal. Which?) Removed Date thereof 4/14/48
(month) (day) (year)

Cemetery or crematory St. Vincent

Location Milville, New Jersey

18. Funeral director W.M. Cook Inc.

Address 1217 St. Paul St.

19. April 6 19 48 A. W. Hedrick
(Date) (ed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1948 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death Coronary Artery Disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Hedrick, M.D.

Address Baltimore, Md.

Date signed 4/1/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03551

40

1. PLACE OF DEATH:

County Baltimore
 City or town Glenarm, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Glenarm, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Long Green Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

JOHN WILLIAM AMREIN

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Annie M. Amrein
 7. Birth date of deceased (mo., day, yr.) Nov. 26th, 1866 6. (c) If alive, give age _____ years
 8. AGE: Years 81 Months 4 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore County, Md.
 (Town, county, and state)
 10. Usual occupation Storekeeper
 11. Industry or business Hardware
 12. Name Henry Amrein
 13. Birthplace Baltimore, Md.
 14. Maiden name Margaret Knipp
 15. Birthplace Germany

16. Informant Mrs. J.W. Amrein
 Address Long Green Rd., Glenarm
 17. burial Date thereof 4/14/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Johns Lutheran
 Location Blenheim
 18. Funeral director Lassahn Funeral Home
 Address 7401 Belair Rd.

19. 4/13/48 19 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH April 12th 1948 at 12:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 21 19 41 to April 12 19 48
 and that I last saw him alive on April 11 19 48

Immediate cause of death Hemiplegia, right
 DURATION

Due to Thrombosis middle cerebral artery 25 days
 Due to Arteriosclerosis

Other conditions Benign enlargement prostate 5 yr +
 (Include pregnancy within 3 months of death)

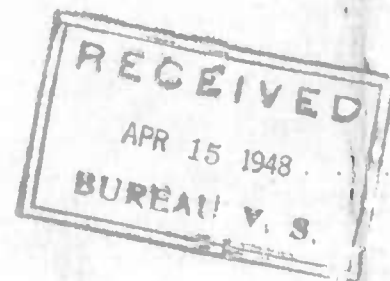
Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE G.W. Bacon M.D. M. D. or other _____
2810 Taylor Ave Address _____ Date signed 4/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Take correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Evidence for change of

are shown on:

FILM No. G 115 APR 27 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 41

03552

1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2803 Dun Glen Court

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 2803 Dun Glen Court
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles R. Applegarth

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Elizabeth Applegarth

7. Birth date of

deceased (mo., day, yr.)

January 28, 1883

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

65 6 4219

hrs.

min.

9. Birthplace

Franklin, Pa.
(town, county, and state)

10. Usual occupation

Pattern Maker

11. Industry or business

Glen L. Martin Co.

12. Name

Robert Applegarth

13. Birthplace

Jennie

14. Maiden name

15. Birthplace

16. Informant

Elizabeth Applegarth

Address

2803 Dun Glen Court, Dundalk

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

April 19, 1948
(month) (day) (year)

Cemetery or crematory

Franklin, Pa.

Location

Franklin, Pa.

18. Funeral director

Roland L. Fisher

Address

2412 Dundalk Ave.

19. (Date filed by registrar)

4/1619. 15R. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 1619. 48at 1:30

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1119. 48to April 1619. 48and that I last saw him alive on April 1519. 48

Immediate cause of death

Myocarditis, Chronic
Coronary Occlusion

DURATION

5 hrs.

Due to

O-S-C-V. Disease

Due to

(x) Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. B. Davis

M. D. or other

Date signed

4/16/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03553

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH:

County Balto.City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town (If outside city or town limits, write RURAL and give nearest town)Street No. 8215 Old Hartford Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dorothy A. Barrett

3. (b) Social Security Number

213-18-3186

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Morris W.

7. Birth date of deceased (mo., day, yr.)

May 11 19216. (c) If alive, give age 27 years

8. AGE:

26 Years

Months

11

Days

9

If less than one day

hrs.min.

9. Birthplace

Balto.
(Town, county, and state)

10. Usual occupation

11. Industry or business

At Home

FATHER

12. Name

Charles Cumberland

13. Birthplace

Balto

MOTHER

14. Maiden name

Mary Hutzler

15. Birthplace

Balto.

16. Informant

Morris W. Barrett Jr.

Address

8215 Old Hartford Rd

17.

(Burial, cremation, or removal, Which?)

Date thereof

4/23/48
(month) (day) (year)

Cemetery or crematory

Morland Memorial Park

Location

Taylor Ave

18. Funeral director

Dippel Bros.

Address

7110 Belair Rd

19.

(Date rec'd by registrar)

April 22 1948 A. W. Haglund

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 201948

at

8:50

P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to April 20 1948and that I last saw him alive on April 20, 1948

Immediate cause of death

DURATION

Pulmonary tbc. 2 1/2 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harold A. Gault, M.D.

M. D. or other

Address 8100 Huford Rd. Date signed 4/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 03554 38

1. PLACE OF DEATH

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 405 E. East Joppa Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna Barthel

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife John Barthel7. Birth date of deceased (mo., day, yr.) Jan. 14 - 1860

6. (c) If alive, give age years

8. AGE: Years 88 Months 3 Days 10 If less than one day hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name Cyrillus Grass13. Birthplace Germany14. Maiden name Sabella15. Birthplace Germany16. Informant Mrs. John GrassAddress 405 E. Joppa Road17. Burial Date thereof 4-27-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Bald18. Funeral director George J. RuckAddress 5305 N. Laurel Road19. 4/26 19 48
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 24 19 48, at 3:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 17 19 48 to Apr. 24 19 48
and that I last saw her alive on Apr. 24 19 48

Immediate cause of death

DURATION

Toxemia
Due to Cardio-vascular
Renal diseaseOther conditions Fracture of R. hip 1 week

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide acc. Date of 4/17/48Where did injury occur? Bald
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Fall

Injured at work?

23. SIGNATURE Dr. A. Sedwick, M.D.

M. D. or other

Address Towson & Md. Date signed 4/24/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

shown on:
 FILE No. G 115 MAY 3 - 1948 CERTIFICATE OF DEATH

2411 N. Charles St., Baltimore

03555

Reg. Dist. No. 48

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 42 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2510 Yorkway

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3. (a) FULL NAME

FRANKLIN H. BECK

3. (b) Social Security Number

unknown

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced6.(b) Name of husband or wife Divorced

6.(c) If alive, give age _____ years

7. Birth date of
deceased (mo., day, yr.)12-17-95

8. AGE:

Years

Months

Days

If less than one day

52 5144

hrs.

min.

9. Birthplace Watertown, N.Y.

(Town, county, and state)

10. Usual occupation Technician

11. Industry or business

FATHER

12. Name Wesley Beck13. Birthplace Rome, N.Y.14. Maiden name Myra Atkins15. Birthplace Oswego, N.Y.16. Informant Clinical Records, Vets. Adm. Hosp.

Address

Ft. Howard, Md.17. Burial
(Burial, cremation, or removal, which?)

Date thereof

4 / 24 / 48
(month) (day) (year)

Cemetery or crematorium

Baltimore National Cemetery

Location

Fredenich Road

18. Funeral director

Address

4914 Belair Road

19.

April 23, 19 48
(Date rec'd by registrar)A. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 19 48 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10, 19 48 to April 21, 19 48and that I last saw him alive on April 21, 19 48Immediate cause of death MYOCARDIAL INFARCTION

DURATION

UnknownDue to Thrombosis left Circumflex
Coronary ArteryUnknown

Due to

Other conditions Cardiac Dilatation and
Hypertrophy, Coronary Arteriosclerosis
(Include pregnancy within 3 months of death)unknown

Major findings of operations

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Raymond J. Lipin MD
M. D. or otherAddress VAH Fort Howard, Md.Date signed 4-22-48

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03556

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.City or town Chesaco Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 lifeHospital, institution, or street address where death occurred:
915 Chesaco Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Chesaco Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 915 Chesaco Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

G. H. Charles Berk

3. (b) Social Security Number

216-10-1455-

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Theresa H. Berk7. Birth date of deceased (mo., day, yr.) 1/19/79

6. (c) If alive, give age years

8. AGE: Years 69 Months 2 Days 28 If less than one day
hrs. min.9. Birthplace Balto. Co. Md
(Town, county, and state)10. Usual occupation Steel Worker11. Industry or business Eastern S. S.12. Name Carl H. Berk13. Birthplace Germany14. Maiden name Katharine M. Stater15. Birthplace Germany16. Informant Miss Anna BerkAddress 915 Chesaco Ave17. Burial Date thereof 4/19/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Zion Lutheran Cem.Location Balto. Co. Md18. Funeral director Lucas Funeral HomeAddress 7401 Belair Rd19. April 18 19 48 pm 5 Grmelly
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 19 48 at 7:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 19 47 to April 19 48and that I last saw him alive on March 10 19 48Immediate cause of death Carcinoma

DURATION

Due to Carcinoma of Pancreas 25 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph P. Cechan, M.D.Address 106 Wilton Rd Date signed 4-17-48

M. D. or other



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 972

CERTIFICATE OF DEATH

Reg. Dist. No. 03557

1. PLACE OF DEATH:

County Baltimore
City or town Chesco Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1020 Chesco Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Baltimore
City or town Chesco Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1020 Chesco Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Georgia Lee Bontz

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Married

6.(b) Name of husband or wife xxx Harry T. Bontz

7. Birth date of deceased (mo., day, yr.) December 23rd 1882

8. AGE: Years Months Days If less than one day
65 3 19 hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Leroy Kidd

13. Birthplace Baltimore, Md.

14. Maiden name Annie Mitten

15. Birthplace Baltimore, Md.

16. Informant Mr Harry T. Bontz

Address 1020 Chesco Avenue.

17. Burial Date thereof April 16 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory xxx St. Mary's Hampden

Location Baltimore, Md.

18. Funeral director Wm. J. Tickner & Sons

Address North & Penna Aves.

19. 4/15 48 A.W.H. Edlich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1948 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h. alive on 19

Immediate cause of death Coronary accident

Due to Immediate

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. M.D.

Address Baltimore, Md. Date signed 4/13/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03558

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.City or town Harmon Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CityCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3605 Burns Lane
(If rural, give LOCATION)

2.(c) If veteran, name war.

3. (a) FULL NAME

James Walter Boone

3. (b) Social Security Number

4. Sex M.5. Color or race W.

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Estella V. Williams6. (c) If alive, give age 87 years7. Birth date of deceased (mo., day, yr.) March 2 - 18868. AGE: Years 87 Months 1 Days 14 If less than one day
.....hrs.min.9. Birthplace Balto. Co.
(Town, county, and state)10. Usual occupation Gardner

11. Industry or business

12. Name John Boone13. Birthplace Md.14. Maiden name Gracie Tipton15. Birthplace Hampden, Md.16. Informant Mrs. Estella BooneAddress 3605 Burns Lane17. Burial Date thereof April 20 - 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. VernonLocation Saylor Ave.18. Funeral director John G. ConnellyAddress 418 Eastern Ave., Essex19. Apr. 20 19 48 John G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 48 2⁰⁰ P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., 19....., 19....., 19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death Coronary Occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John G. Connelly M.D. or otherAddress 418 Eastern Ave., EssexDate signed 4/17/48

RECEIVED

APR 27 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03552 38

1. PLACE OF DEATH:

County... BALTO
City or town... TOWSON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
WOODBROOK LANE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County...
City or town... TOWSON
(If outside city or town limits, write RURAL and give nearest town)
Street No. WOODBROOK LANE
(If rural, give LOCATION)
2. (a) If veteran, name war... WW # 1

3. (a) FULL NAME

THOMAS R. BOTTS

3. (b) Social Security Number

yes

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife... L. Amelia

7. Birth date of deceased (mo., day, yr.) Sept 29, 1890 6. (c) If alive, give age... years

8. AGE: Years 57 Months 6 Days 15 It less than one day... hrs. min.

9. Birthplace... Flemingsburg, Ky
(Town, county, and state)

10. Usual occupation... Chain Broker

11. Industry or business

12. Name... Arthur R. Botts

13. Birthplace... Ky

14. Maiden name... Lucy M. Luddick

15. Birthplace... Ky

16. Informant... L. Amelia Botts

Address... Woodbrook Lane, Towson, Md

17. Burial (Burial, cremation, or removal, which?) Date thereof... 4/16/48 (month) (day) (year)

Cemetery or crematory... Flemingsburg, Ky

Location... Wm J. Vickrey & Sons

18. Funeral director... Baltimore

Address... 415 N. W. Hedrick

19. (Date rec'd by registrar) 19 48 Registrar Wm

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 14 19 48 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46, to April 14 19 48

and that I last saw him alive on April 7 19 48

Immediate cause of death... Cardiac Failure

Chronic Tuberculosis

Due to... 2 months

Due to... 12 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... William P. Garlick, M.D.

Address... 2 West Road Date signed... April 14, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

03560

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore

City or town Centertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Int. P. Pleasant Sanatorium

How long in hospital or institution? Since June 5, 1946

3. (a) FULL NAME

Samuel Bozin

3. (b) Social Security Number

218-10-5936

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 28, 1916

8. AGE:

Years 32 Months 1 Days 24 If less than one day hrs. min.

9. Birthplace

Baltimore Md.
(Town, county, and state)

10. Usual occupation

Clerical Worker

11. Industry or business

Samuel Bozin

12. Name

Russia

13. Birthplace

Soske ?

14. Maiden name

Russia

15. Birthplace

Inform Bozin (brother)

620 N. Euter St. Baltimore

17. (Burial, cremation, or removal (which?))

Burial Date thereof 4-23-48
(month) (day) (year)

Cemetery or crematory

Rosedale

Location

Phelp Rd & Hamilton Ave

18. Funeral director

Jack Lewis Inc

Address

2100 Euter Place

19. (Date recd by registrar)

4/23 19 48 D.W. Hedrick Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 620 N. Euter Street

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1948 at 8:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 5, 1946 to April 22, 1948

and that I last saw him alive on April 22, 1948

Immediate cause of death

Myocardial failure

DURATION

Due to Pulmonary tuberculosis 2 years

Due to Diabetes mellitus 6 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Prohler MD

M. D. or other

Address Centertown Md. Date signed 4/22/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County BaltimoreCity or town Refae
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr 2 mo 28 da.

Hospital, institution, or street address where death occurred:

Baltimore County Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Chase Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George Henry Bronson

3. (b) Social Security Number

4. Sex

male

5. Color or race

col

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Nov. 27-1882

6.(c) If alive, give age _____ years

8. AGE: Years Months Days It less than one day

65 5 3 hrs. min.9. Birthplace Guyson Brook, Md
(Town, county, and state)10. Usual occupation Labour

11. Industry or business _____

12. Name James Bronson13. Birthplace Maryland14. Maiden name Maria Davis15. Birthplace Maryland16. Informant Mr Charles BronsonAddress Chase, Maryland17. Burial Date thereof 5 2 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount PleasantLocation Baltimore Co., Md. Living Mills18. Funeral director Charles E. CooperAddress 510-12 Carlton Ave Balto19. Apr. 30 19 48 Wm J. Chilcote
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Died Apr 29 19 48 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/29 19 47 to 4/29 19 48and that I last saw him alive on 4/29/48 19Immediate cause of death Uremic Coma

DURATION

3 daysDue to Chronic Nephritis

Due to _____

Other conditions Arterio sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

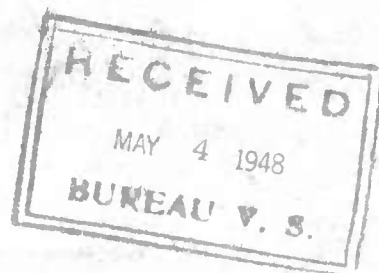
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wilmer C. Egan M.D. M. D. or otherAddress Cockeysville Md. Date signed 4/30/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH *Baltimore*
 County.....
 City or town.....*Harrison*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *2 yrs.*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*md* County.....*Baltimore*
 City or town.....*Harrison*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Herbert Maxwell Brune

3. (b) Social Security Number

4. Sex *m.* 5. Color or race *w.* 6.(a) Single, married, widowed, or divorced *married*
 6.(b) Name of husband or wife.....*Anne Triplett Harrison*
Brune 6.(c) If alive, give age *78* years
 7. Birth date of *Oct 14, 1866*
 deceased (mo., day, yr.)
 8. AGE: Years *81* Months *5* Days *30* If less than one day
 hrs. min.

9. Birthplace.....*Baltimore md*
 (Town, county, and state)
 10. Usual occupation.....*attorney*
 11. Industry or business

FATHER 12. Name.....*Frederick Brune*
 13. Birthplace.....*Maryland*
 MOTHER 14. Maiden name.....*Emily Barton*
 15. Birthplace.....*Virginia*

16. Informant.....*Mrs. Herbert M. Brune*
 Address.....*704 Leigh, Harrison, md*
 17. *Burial* Date thereof.....*Apr 15 1948*
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory.....*Green Mount*
 Location.....*Baltimore md*

18. Funeral director.....*Servy W. Jenkins & Son Co*
 Address.....*McCallister Orchard Sts*

19. *4/18* 19. *48* *SW Hedrick*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*13 Apr* 19. *48* at *7:25 PM*
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Apr. 19. *48* to *13 Apr* 19. *48*
 and that I last saw him alive on *12 Apr 48*
 Immediate cause of death.....*cardiorespiratory failure* DURATION *1 hr*
 Due to.....*Cerebral vascular accident* *1 yr*
 Due to.....*Hypertensive cardiorespiratory disease* *4 yrs*
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....*Paul H. Royce M.D.* M. D. or other
 Address.....*Pikesville 8, md* Date signed.....*13 Apr 48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... BaltimoreCity or town... Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Int. Pleasant SenatoriumHow long in hospital or institution? Since August 25, 1947

3. (a) FULL NAME

Frederic C. Bryan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

August 12, 1909

6. (c) If alive, give age ... years

8. AGE:

Years 39 Months 8 Days 8 If less than one day
hrs. min.

9. Birthplace

Baltimore Maryland
(Town, county, and state)

10. Usual occupation

Meter Reader

11. Industry or business

12. Name Frederic C. Bryan13. Birthplace U. S. A.14. Maiden name Hellie Benton15. Birthplace U. S. A.

16. Informant

Alade Jorney
Address 1861 N. Collington Ave.17. Burial Date thereof Apr 23/48
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory ParkwoodBaltimoreLocation Philips Herwig Mrs18. Funeral director 2024 Orleans StAddress April 21 19 4819. April 21 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1861 N. Collington Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1948 at 7:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 25, 1947 to April 20, 1948and that I last saw him alive on April 20, 1948

Immediate cause of death

Myocardial Infarct

DURATION

Due to Pulmonary Tuberculosis 10 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy result Pulmonary Tuberculosis, Endocardial

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Querner M.D. M. D. or otherAddress Reisterstown Date signed 4/20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PL. WITH UNFADING INK. Supply every item of information. Fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 32 years, 10 months, 29 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 32 years, 10 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 172 S. Arlington Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Stephen Burroughs

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced SINGLE married
 6. (b) Name of husband or wife Amelia C.
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 13th 1881
 8. AGE: Years 66 Months 10 Days 7 It less than one day _____ hrs. _____ min.
 9. Birthplace Ohio
 (Town, county, and state)
 10. Usual occupation Black smith helper
 11. Industry or business B & O Rail Road
 12. Name Alexander Burroughs
 13. Birthplace Ohio
 14. Maiden name Elizabeth Schaeffer
 15. Birthplace Ohio

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof 4/24/48
 (Burial, cremation, or removal. Which?) (Month) (day) (year)
 Cemetery or crematory Mt Olivet Cem
 Location 2930 Frederick Ave
 18. Funeral director John F. Cowan & Son
 Address 921-03 Hollins St.
 19. April 22, 1948 A. W. Hedrick
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 19 48 at 7:45 p. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 19 15 to April 20 19 48
 and that I last saw him alive on April 20 19 48

Immediate cause of death Acute pericarditis DURATION one week
 Due to Chronic valvular heart disease indefinite
 Due to Interstitial nephritis "
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____
 Address Catonsville-28, Md. Date signed 4-21-48

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 4

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address... 609 Delaware Ave.
(c) Hospital or institution: Essex, Balto. Co., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Essex
(c) City or town Baltimore County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Delaware Ave.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME

RAYMOND E. CANNON

3 (b) If veteran, name war

WORLD WAR II

3 (c) Social Security Account

No. 216-01-5515

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

married

6 (b) Name of husband or wife

Sina A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 7-1912

8. AGE:

Years

Months

Days

If less than one day

36

0

3

hr. min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual Occupation

Saladman

11. Industry or business

Coca Cola Co.

12. Name

James Crawford Cannon

13. Birthplace

Md.

14. Maiden Name

Florence Baine

15. Birthplace

Va.

16 (a) Informant

Mrs. Sina Cannon

(b) Address

609 Delaware Ave

17 (a)

Burial

(b) Date thereof

4-12-48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Moreland Park

Location

Balto.

18 (a) Funeral director

L. J. Luck

(b) Address

5305 Hartford Rd.

19 (a)

APR 12 1948

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 10, 1948

at M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Lobar pneumonia

Fatty degeneration of liver

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public

place?..... While at work?.....

(d) Means of injury.....

23. Signature George A. Merrill M.D.

Date signed 4/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age especially important. Physicians: please write the causes of death clearly and legibly.

MD
MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 1318
CERTIFICATE OF DEATH

03565

Reg. Dist. No. *47*

1. PLACE OF DEATH:
County..... Baltimore
City or town..... Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 5 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution?..... 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1831 Orleans Street
(If rural, give LOCATION)
2.(a) If veteran, name war..... WW-I ✓

3. (a) FULL NAME

RAY CHAMBERS

3. (b) Social Security Number

Unknown

4. Sex..... Male 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Married
6.(b) Name of husband or wife..... Frances Chambers
7. Birth date of deceased (mo., day, yr.)..... 8-29-1900 6.(c) If alive, give age..... 46 years
8. AGE: Years..... 47 Months..... 7 Days..... 23 It less than one day..... hrs. min.

9. Birthplace..... Pennsylvania
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

MOTHER FATHER
12. Name..... Unknown
13. Birthplace..... "
14. Maiden name..... "
15. Birthplace..... "

16. Informant..... Clinical Records, Vets. Adm. Hosp.
Address..... Fort Howard, Maryland

17. Burial Date thereof..... 4/16/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetary or crematory..... Hampton National Cemetery
Hampton, Virginia
Location.....

18. Funeral director..... Charles R. Law
Address..... 802 Madison Ave., Balto. Md.

19. 4/13 48 D.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 12, 1948, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
April 7, 1948, to April 12, 1948
and that I last saw him..... alive on April 12, 1948

Immediate cause of death..... Cardiac Dilatation and hypertrophy DURATION..... Unknown

Due to..... Chronic Nephritis Unknown

Due to.....

Other conditions..... none

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results..... Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury..... Injured at work?

23. SIGNATURE..... H.C. Manough
H.C. MANAUGH, M.D. Chief Professional
Address..... VAH, Ft. Howard, Md. Date signed..... Ser. 4-13-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

03566

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.
City or town Mobile River Inst.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

at Martins Plant
How long in hospital or institution Adms. Bldg. Airport

3. (a) FULL NAME

Robert Ernest Chapin

3. (b) Social Security Number

273-057-645

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Marilla (Coolidge)

7. Birth date of deceased (mo., day, yr.)

Dec 9/1895

6. (c) If alive, give age _____ years

8. AGE:

Years 52

Months 4

Days 6

If less than one day

hrs. _____ min.

9. Birthplace

Sharon, Ohio

10. Usual occupation

Electrician

11. Industry or business

Martins Plant

FATHER

12. Name

Charles R. Chapin

MOTHER

13. Birthplace

Ohio

14. Maiden name

Ida Crawford

15. Birthplace

Ohio

16. Informant

Mr. Marilla Chapin

Address

1621 Darnford Rd. M. River

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 19-48
(month) (day) (year)

Cemetery or crematory

Baltimore National

Location

Federick Road

18. Funeral director

John G. Connolly

Address

418 Eastern Ave. Essex

19. 4/16/

(Date rec'd by registrar)

19 48

John G. Connolly

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Balto.

City or town Baltimore Co. Co.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1621 Darnford Rd
(If rural, give LOCATION)

2. (a) If veteran, name war World War #1

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 15 1948 at 4:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

_____ Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. William B. D.

Deputy Medical Examiner M. or other _____

Address Balto Co. Darnford Rd Date signed 4/15/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH;
County Baltimore
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 71 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution? 71 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 104 (Crain Highway N.E.
(If rural, give LOCATION)
2. (a) If veteran, name war WW I

3. (a) FULL NAME

AUGUST P. CLAUSS

3. (b) Social Security Number

218 14 7685

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mrs. Catherine Clauss
7. Birth date of deceased (mo., day, yr.) 12-8-96 6. (c) If alive, give age 28 years
8. AGE: Years 51 Months 4 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Glen Burnie, Md.
(Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business _____
12. Name William Clauss
13. Birthplace Baltimore, Maryland
14. Maiden name Barbara Blackstone
15. Birthplace Germany

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial May 1, 1948
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie, Md.
18. Funeral director Thomas W. Singleton
Address Glen Burnie, Md.
19. May 3 48 Warren L. Parker
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 48 at 9:17 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17 19 48 to April 28 19 48
and that I last saw him alive on April 28 19 48
Immediate cause of death Cirrhosis of liver
Cause Unknown
DURATION 1-1/2 Yrs.
plus
Due to _____
Due to _____
Other conditions Anasarca, pulmonary edema 1-1/2
& atelectasis due to above. Mos. plus
Sub-acute Nephritis, cause unknown 10 days
Major findings of operations _____ plus
Date of op. _____
Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: It death was due to external causes, till in the following;
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, pub'c place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE H.C. MANAUGH
H.C. MANAUGH, M.D. Chief Professional Ser.
VAH, Ft. Howard, Md. 4-29-48
Date signed _____

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

03568

Reg. Dist. No. 3/

1. PLACE OF DEATH. County..... Baltimore City or town..... Woodlawn (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: 6405 Lehnert Ave. How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... Md. County..... Baltimore City or town..... Woodlawn (If outside city or town limits, write RURAL and give nearest town) Street No. 6405 Lehnert Ave. (If rural, give LOCATION) 2.(a) If veteran, name war	
3. (a) FULL NAME Augusta Collins		3. (b) Social Security Number	
4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Widow	
6. (b) Name of husband or wife Late Henry W. Collins			
7. Birth date of deceased (mo., day, yr.) March 3, 1872			
6. (c) If alive, give age years			
8. AGE: 76	Years 1	Months 13	Days 13
It less than one dayhrs.min.			
9. Birthplace. Baltimore, Md. (Town, county, and state) H. W.			
10. Usual occupation			
11. Industry or business			
FATHER	12. Name Dorner		
	13. Birthplace Unknown		
MOTHER	14. Maiden name Unknown		
	15. Birthplace Unknown		
16. Informant Mrs. Dorothy Frizzell Address 6405 Lehnert Ave. Woodlawn, Md.			
17. Burial (Burial, cremation, or removal. Which?) Woodlawn Cemetery or crematory Woodlawn, Md. Location Harry H. Whitely 18. Funeral director Address 4101 Edmondson Ave.			
19. Date April 19, 1948 (Date rec'd by registrar)			
20. DATE OF DEATH April 16/48. 19..... at 3.40 P.M.			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 19..... to April 16 19..... and that I last saw him/her alive on April 15 19..... Immediate cause of death Generalized arteriosclerosis Other conditions (Include pregnancy within 3 months of death) Major findings of operations No Autopsy results No PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Where did injury occur? (City or town) (County)* (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
23. SIGNATURE 2818 St. Pauls Address Date signed 4/17/48			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03569

30

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: **Baltimore**
 County.....
 City or town..... **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **3 years 6mo.s 6 days.**
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? **3 years, 6 months, 6 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Maryland** County..... **Baltimore**
 City or town..... **Bonny Blink**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **Masonic Home**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Emily B. Conser

3. (b) Social Security Number

4. Sex..... **Female** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Widowed**
 6. (b) Name of husband or wife..... **Charles C. Conser, M. D.**
deceased 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) **July 15, 1877**
 8. AGE: Years..... **70** Months..... **6** Days..... **25** If less than one day..... hrs. min.

9. Birthplace..... **Baltimore, Maryland**
 (Town, county, and state)
 10. Usual occupation..... **Housewife**
 11. Industry or business..... **Home**
 FATHER 12. Name..... **Reverend G. G. Baker**
 13. Birthplace..... **Catonsville, Vermont**
 MOTHER 14. Maiden name..... **Cynthia M. Stanley**
 15. Birthplace..... **New Hampshire**

16. Informant..... **Hospital Records**
 Address..... **Catonsville, 28, Md.**
 17. **Burial** Date thereof..... **April 12-48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **London Park**
 Location..... **Frederick Road**
 18. Funeral director..... **William Cook Inc**
 Address..... **1217 St Paul Street**
 19. **4-10** 19 **48** **Dr. A. W. Hedrick** Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **April 9, 1948** 19..... **8:45 A. M.**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 3 1944 19..... to..... **April 9, 1948**
 and that I last saw h..... **er** alive on..... **April 9, 1948** 19.....
 Immediate cause of death..... **Pulmonary oedema**

	DURATION
Due to..... Subdural hemorrhage	1 hour
Due to..... Hypertensive C-V-R disease	Indef.
Generalized atherosclerosis.....	"
Other conditions..... Arteriosclerotic Heart Dis.	"
Cerebral arteriosclerosis	"
(Include pregnancy within 3 months of death)	

Major findings of operations..... Date of op.....
 Autopsy results..... **as above**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... **Henry C. A. Mead, M.D.** M. D. or other
 Address..... **Catonsville, 28, Md.** Date signed..... **4/9/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville Ind
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 months
 Hospital, institution, or street address where death occurred:
Maroonie Home, Cockeysville Ind
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1338 Hollins St
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Florence Bessie Corprew CORPREW

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Moses J. Corprew
 7. Birth date of deceased (mo., day, yr.) July 20th 1973 6.(c) If alive, give age _____ years
 8. AGE: Years 74 Months 8 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business _____
 12. Name James Edward Brooks
 13. Birthplace Baltimore Md
 14. Maiden name Ellen Squires
 15. Birthplace Baltimore Md

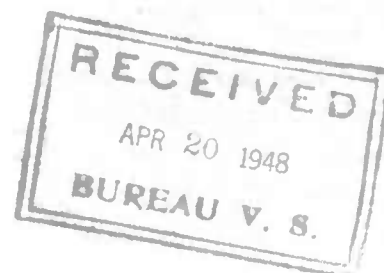
16. Informant Laura M. Schroeder
 Address Maroonie Home, Cockeysville Ind
 17. Burial Date thereof April, 19 48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Linden Pk.
 Location Baltimore Md
 18. Funeral director Mrs. Cook
 Address St. Paul & Preston St
 19. April 19 48 L.M. Schroeder
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 48 at 4:45 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 19 47 to April 16 19 48
 and that I last saw her alive on April 16 19 48
 Immediate cause of death Cerebral Accident DURATION one week
 Due to Hypertension
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Walter J. Kees M.D. M. D. or other _____
 Address Cockeysville Md Date signed 4/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03571

Reg. Dist. No. 57

1. PLACE OF DEATH:

County BaltimoreCity or town Lincolnton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Lincolnton
(If outside city or town limits, write RURAL and give nearest town)Street No. York Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.

No

3. (a) FULL NAME

Mary Ellen Corahey

3. (b) Social Security Number

none

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Thomas J. Corahey

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 18, 1867

8. AGE:

Years

80

Months

8

Days

22

If less than one day

hrs.

min.

9. Birthplace

Balto. Co., Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Michael Brady

13. Birthplace

Ireland

14. Maiden name

Winifred Monahan

15. Birthplace

Ireland

16. Informant

Mrs. Mary Marx

Address

Lincolnton Md.

17. (Burial, cremation, or removal, Which?)

BurialDate thereof Apr. 12, 1948
(Month) (day) (year)

Cemetery or crematory

St. Joseph's

Location

Texas, Md.

18. Funeral director

Sandon M. Brooks

Address

Sparks, Md.

19.

4-10-48Wilmer C. Ensor

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 919 48at 7:30 P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July19 47

to

4/919 48

and that I last saw him alive on

4/919 48

Immediate cause of death

Heart Failure

DURATION

1 week

Due to

Coronary Artery Sclerosis

Due to

1 yr

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles F. O'Donnell MD

M. D. or other

Address

7301 York Rd. Towson

Date signed

4/9/48

RECEIVED

APR 14 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03582

1. PLACE OF DEATH:

County Baltimore
City or town Fullerton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Fullerton, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 Henry Ave.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

HELEN A. CREASY

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Charles F. Creasy
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) January 26th, 1914
8. AGE: Years 34 Months 2 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace York, Pa.
(Town, county, and state)
10. Usual occupation at home
11. Industry or business
12. Name George Strack
13. Birthplace Pa.
14. Maiden name Nettie Hoffman
15. Birthplace Pa.

16. Informant Mr. Charles F. Creasy
Address 18 Henry Ave.
17. burial Date thereof 4/21/48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Greenmount
Location York Pa.
18. Funeral director Lasscha Funeral Home
Address 7401 Belair Rd.

19. Apr 19 '48 Mr. G. L. Rippin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17th, 1948, at 10:55 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from see 1st 1947, to April 17, 1948
and that I last saw him alive on April 17th 1948

Immediate cause of death Lupus erythematosus
Lupus disseminatus DURATION 3 weeks

Due to Acute nephritis 4 1/2 months

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

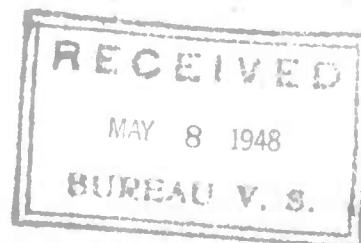
23. SIGNATURE W. Overman M. D. or other
Address W. Overman Date signed 4/18/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03573

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.
 City or town Middle River
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto
 City or town Middle River
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Homeland Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Helen L.

7. Birth date of deceased (mo., day, yr.) Feb. 16 of 1908 6.(c) If alive, give age years

8. AGE: Years 40 Months 2. Days hrs. min.

9. Birthplace New York
 (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business

12. Name Frank B. Crowther13. Birthplace Penna14. Maiden name Caroline S. (Schmidt)15. Birthplace Penna.16. Informant Mrs. Helen CrowtherAddress 9 Homeland Ave.17. Removal Date thereof Apr. 10-48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Glen Funeral HomeLocation Wilkes Barre, Penna.18. Funeral director John B. ConnollyAddress 418 Eastern Ave.19. Apr. 10 - 1948 John B. Connolly

(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10th 1948, at 9:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Hypertension Cardio Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. B. Davis M.D.Address 1111 N. D. St. Date signed 4/11/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03574 41

1. PLACE OF DEATH

County Baltimore

City or town Dundalk Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, institution, or street address where death occurred:

6720 Brentwood Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6720 Brentwood Ave 636 S. Macaul St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Alfonso Danna

3.(b) Social Security Number

4. Sex

male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

B.(b) Name of husband or wife xxx Anna Danna

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13 1873

8. AGE:

Years

Months

Days

If less than one day

74

6

13

hrs. min.

9. Birthplace Cianciano Girenti Italy

(Town, county, and state)

Retired

10. Usual occupation

11. Industry or business

12. Name Antonio Danna

13. Birthplace

Italy

14. Maiden name Gaetana Cona

15. Birthplace

Italy

16. Informant Anna Danna (Wife)

Address

6720 Brentwood Ave (Dundalk Md).

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof April 29/48

(month) (day) (year)

Cemetery or crematory Sacred Heart Cemetery

Location Germanhill Rd. Dundalk Md.

18. Funeral director

Address

52 N. Morley St.

19. 4/28
(Date rec'd by registrar)

xs

A.W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26- 19 48 at 23⁰⁰ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-16-46 19 46 to 4-26 19 48

and that I last saw him alive on 4-26-48 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 2 hours

Hypertension Cardiovascular disease 3-4 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eugene F. New M. D. or other

Address 7001 Washington Rd Date signed 4/27-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03575

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore Parkville, Md
 City or town Fern + Putty Hill Aves.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Parkville
 City or town Parkville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Fern + Putty Hill Aves
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George De Graw

3. (b) Social Security Number

484-07-0161

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Margaret De Graw

7. Birth date of deceased (mo., day, yr.) September 3, 1883 6. (c) If alive, give age 65 years

8. AGE: Years 64 Months 7 Days 4 If less than one day
 hrs. min.

9. Birthplace Iowa
(Town, county, and state)10. Usual occupation Former Watchman
Unemployed11. Industry or business Unemployed12. Name Ephraim De Graw13. Birthplace Iowa

14. Maiden name

15. Birthplace

16. Informant Mrs. Marie De GrawAddress 5302 Sippel Ave17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 4/9/48
(month) (day) (year)Cemetery or crematory Parkwood Cemetery
Location Taylor Ave
Howard W. Blight & Co.
Address 6009 Bayview Road18. Funeral director Howard W. Blight & Co.
Address 6009 Bayview Road19. April 8 19 48 R. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 48 at 1:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/7 19 48 to 4/7 19 48and that I last saw him alive on 4/7 19 48

Immediate cause of death

Due to arteriosclerotic cardio-vascular diseaseDue to Broncho-pneumonia 3 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harold A. Groat, M.D.
M. D. or other 8100 Harbor Rd.
Address 8100 Harbor Rd. Date signed 4/9/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03576 30

1. PLACE OF DEATH:

Baltimore
County.....
City or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 28 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 months 28 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland..... County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3113 Rosalie Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Irene Dempsey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife William P. Dempsey
7. Birth date of deceased (mo., day, yr.) February 13, 1877
8. AGE: Years 71 Months 1 Days 27 It less than one day
hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home

12. Name Charles James
13. Birthplace Maryland
14. Maiden name Anna Thiele
15. Birthplace Maryland

16. Informant Hospital records Wm P. DEMPSEY (HUSBAND)
Address Catonsville, 28, Md. 2652 HARGO AVE

17. BURIAL Date thereof 4/14/48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Loudon Pk.
Location BALTO. MD.

18. Funeral director Wm St. TIGHE & Sons
Address BALTO. MD.

19. APR 12 1948
(Date rec'd by registrar) 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1948 19..... at 6:20 pm
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13, 1948 19..... to April 10, 1948
and that I last saw h ~~is~~ alive on April 10, 1948 19.....
Immediate cause of death Bronchopneumonia
bilateral; lower
Cerebral accident
Due to Arteriosclerotic heart disease
Arteriosclerosis generalized
Due to Hypertensive cardio-vascular
-renal disease
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
Autopsy results As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M. D.
M. D. or other
Address Catonsville, 28, Md. Date signed 4/11/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PL. WITH UNFADING INK. Supply every item of information. is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Approx. 6 Hrs.

Hospital, institution, or street address where death occurred:

Vets. A.M. Hospital, Ft. Howard, Md.How long in hospital or institution? Approx. 6 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 734 W. Saratoga St.,
(If rural, give LOCATION)2. (a) If veteran, name war WW I ✓

3. (a) FULL NAME

JOHN R. DOUGLASS

3. (b) Social Security Number

unknown

4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Married—Sep.</u>
-----------------------	------------------------------------	---

6. (b) Name of husband or wife Martha Douglass7. Birth date of deceased (mo., day, yr.) 10-29-18978. AGE: Years Months Days If less than one day
50 6 0 hrs. min.9. Birthplace Washington, D. C.
(Town, county, and state)10. Usual occupation Chauffeur

11. Industry or business

12. Name Douglass13. Birthplace Virginia14. Maiden name Annie ?15. Birthplace unknown16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Md.17. Burial 5/5/48
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation 5501 Frederick Rd. Balto. Md.18. Funeral director Mrs. Katie R. WilliamsAddress 322 N. Schroeder St. Balto. Md.19. 5-4 19 48 Dr. Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 19 48 at 4:45 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 29, 19 48 to April 30, 19 48and that I last saw him alive on April 30, 19 48Immediate cause of death MYOCARDIAL FAILUREDURATION
2 weeksDue to Hypertensive heart disease1 year
plus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William H. Haskett M. D. or otherAddress Ft. Howard, Md. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

03578

1. PLACE OF DEATH:

County Harford Co

City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:
6100 Edmondson ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balls

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6100 Edmondson ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louis Rudasco

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced ?

6. (b) Name of husband or wife ?

7. Birth date of deceased (mo., day, yr.) Aug 24 1885

8. AGE: Years 62 Months 7 Days 10 If less than one day hrs. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Care taker

11. Industry or business Home Gardens

12. Name

13. Birthplace Italy

14. Maiden name

15. Birthplace Italy

16. Informant Mrs Mary D Kennedy

Address 6100 Edmondson ave

17. (Burial, cremation, or removal, Which?) Burial Date thereof Apr 05 48
(month) (day) (year)

Cemetery or crematory New Catholic

Location Beggs City

16. Funeral director Edw J Mar Nabb

Address Catonsville Md

19. April 4 48 V.E. Harry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 48 at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , 10 19 and that I last saw h alive on 19

Immediate cause of death

Coronary occlusion

Due to

Cardiovascular disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Dr. M. Kieffer Raymond

M. D. or other

Address 1010 Leaden Date signed 4-3-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 6 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

03579

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 4030 Park Heights Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

F
Edward Dunnoek

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Mary A. Gibney (Dunnoek)

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25, 18738. AGE: Years Months Days If less than one day
74 8 0 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farming12. Name Samuel F. Dunnoek13. Birthplace Baltimore, Md.14. Maiden name Alice F. Jones15. Birthplace Baltimore, Md.16. Informant Hospital RecordsAddress Baltimore 28, Maryland17. Burial Date thereof 4/28/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Landon ParkLocation Balto. Md.18. Funeral director William Cook IncAddress 1217 St. Paul St.19. 4/22 48 D.W. Hedrick
(Date rec'd by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19 48 at 3:10 pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 8 19 48 to April 25 19 48and that I last saw him alive on April 25 19 48Immediate cause of death Bilateral Lobar Pneumonia - Undetermined Origin DURATION 8 hours~~Also~~ Coronary Thrombosis less than 1 hour~~Also~~ Arteriosclerotic Heart Disease Indefinite

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk M.D. or otherAddress Catonsville 28, Md. Date signed 4/26/48

WITH UNFADING INK. Supply every item of information, especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

03580

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

House of the Pines 16 Fusting Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____

City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 119 S. Wickham road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MINNIE J. ELLIS

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife --- 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 27, 1869

8. AGE: Years 78 Months 10 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Ireland
 (Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER 12. Name John Ellis
 13. Birthplace Ireland

MOTHER 14. Maiden name Mary A. Kenealy
 15. Birthplace Ireland

16. Informant Mrs. Katherine Yockel
 Address 119 S. Wickham road

17. Burial Date thereof 4/24/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cathedral

Cemetery or crematory 4300 Old Frederick road
 Location

18. Funeral director Chas J. Evans, Son, Inc.
 Address 118 N. Mt. Royal Ave.

19. 4/22 19 48 VE. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 48 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 19 45 to April 21 19 45 and that I last saw him alive on April 20 19 45

Immediate cause of death Metastatic Ca of Breast DURATION 3 mo

Due to Ca of Breast 132

Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William K. Gallagher, M.D. M. D. or other
 Address Catonsville-28, Md Date signed 4/22/48

67 1391
1242
FEB 31 35
Dr. Gallagher

6209 FREDERICK AVE

RECEIVED

APR 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

03581

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3417 Falls Rd.
(If rural, give LOCATION)
2. (a) If veteran, name war WW I

3. (a) FULL NAME

HORACE J. EMERSON, Sr.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Grace Emerson
6. (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) 5-2-95
8. AGE: Years 52 Months 11 Days 15 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 48 at 9:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 48 to April 17 19 48
and that I last saw him alive on April 17 19 48
Immediate cause of death Infarction of right & left ventricle

DURATION

Due to Thrombosis left ant. coronary artery 3 day Plus
Due to Coronary arteriosclerosis unknown
Other conditions Cardiac dilatation & hypertrophy
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Richard N. Land RICHARD N. LAND, M.D. M. D. or other
Address VAH Fort Howard, Md. Date signed 4-18-48

9. Birthplace Brazil (Town, county, and state)
10. Usual occupation Electrician
11. Industry or business _____
12. Name Lucien Emerson
13. Birthplace South America
14. Maiden name Rosa Hamberton
15. Birthplace Maryland
16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial Date thereof 4/20/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Md.
18. Funeral director Howard N. Blight, Jr.
Address 4914 Belair Rd., Baltimore, Md.
19. April 19 19 48 A. W. Delush
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03582

Reg. Dist. No. 37

1. PLACE OF DEATH:

County BaltimoreCity or town Texas
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 yr 25 da

Hospital, institution, or street address where death occurred:

Baltimore County HomeHow long in hospital or institution? 14 yr 25 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Texas
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Patrick Findley

3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Mary Findley

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 18618. AGE: Years 87 Months 3 Days 23 If less than one day _____ hrs. _____ min.9. Birthplace New York
(Town, county, and state)10. Usual occupation Farm Laborer

11. Industry or business

12. Name John Findley13. Birthplace Ireland14. Maiden name Margaret Maloney15. Birthplace Ireland16. Informant Mrs Edger SheCortAddress 1909 Forbes St - Pittsburgh, Pa.17. Burial Date thereof May 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore County HomeLocation Texas Ind.18. Funeral director London M. BrooksAddress Spurk's. ind.19. April 30 1948 Wm J. Philcoat
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 48 at 11 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/5 19 34 to 4/29 19 48and that I last saw him alive on 4/29 19 48Immediate cause of death Cerebral aneurysm of liver. DURATION 2 yr.

Due to _____

Due to _____

Other conditions Arteriosclerosis -Jaundice -
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

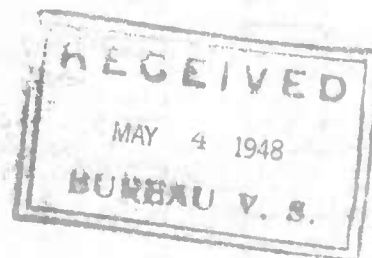
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William C. Emerson M.D. M. D. or otherAddress Cockeysville Ind. Date signed 4/30/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

03583

97

1. PLACE OF DEATH:

County BaltimoreCity or town Bethesda - 8
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

215 Clarendon Dr.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Bethesda - 8
(If outside city or town limits, write RURAL and give nearest town)Street No. 215 Clarendon Drive
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Katharine May Fisher

3. (b) Social Security Number

4. Sex F.5. Color or race W.6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife William J. Fisher

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 20, 18608. AGE: Year 87 Months 7 Days 3 It less than one day

hrs. min.

9. Birthplace Wheaton, Md.
(Town, county, and state)10. Usual occupation H. W.11. Industry or business H. W.12. Name Eliza Stamen13. Birthplace Unknown14. Maiden name Wm. De Moss15. Birthplace Unknown16. Informant Harry F. FisherAddress 215 Clarendon Dr. Bethesda, Md.17. Burial Date thereof Apr. 26, 48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory SpringLocation Woodlawn, Md.18. Funeral director Harry W. HancockAddress 4204 Bridgewood Dr.19. 4/24/48 19 48 Registrar R. J. Hedrick

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 April 19 48 at 4:45 P.

21. I CERTIFY that death occurred on the date above elated: that I attended deceased from

23 January 19 48 to 23 April 19 48and that I last saw him alive on 20 April 19 48

Immediate cause of death

Cerebralarteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Charles H. Williams M.D.Address Bethesda - 8 - Md. Date signed 23 Apr. 48

RECEIVED

MAY 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY IN UNFADING INK. Supply every item of information, and legibly. is esp. important. Physicians: please write the causes of death clearly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03584

50

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville 28, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6304 Blackburn Court
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Kimbrough
Pauline A. Fleming

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, or divorced Married
 6.(b) Name of husband or wife Dorsey J. Fleming
 6.(c) If alive, give age 57 years
 7. Birth date of deceased (mo., day, yr.) March 9, 1887
 8. AGE: Years 61 Months 0 Days 14 If less than one day hrs. min.

9. Birthplace Bremo Bluff, Virginia
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Domestic

12. Name Melvin H. Kimbrough

13. Birthplace Virginia RICHMOND

14. Maiden name EDITH NEEDLE Pettit

15. Birthplace Virginia

16. Informant Hospital Records DORSEY J. FLEMING

Address Catonsville 28, Md. Court

17. BURIAL Date thereof 4/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or mausoleum Bremo Bluff, Va.

Location

18. Funeral director Wm J. Ticker & Sons

Address BA L to, MD.

19. 4/24 48 Wm J. Ticker
 (Date rec'd by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1948 at 5:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 17 1948, to April 23 1948

and that I last saw her alive on April 23 1948

Immediate cause of death

Arteriosclerotic heart disease DURATION indefinite

Due to Arteriosclerosis, generalized

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D.

Address Catonsville-28, Maryland Date signed 4-23-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03585

1. PLACE OF DEATH:

County Bald Co.
 City or town Fullerton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Bald.
 City or town Fullerton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Margaret M. Foster Foster

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Feb. 1 - 1878 6.(c) If alive, give age _____ years

8. AGE: Years 70 Months 7 Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Penn. (Town, county, and state)10. Usual occupation House Wife

11. Industry or business _____

12. Name Unknown13. Birthplace "14. Maiden name "15. Birthplace "16. Informant Irwin D. FosterAddress Fullerton Md.17. Burial Date thereof April 19 - 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Stephens Cem.Location Bradshaw Md.18. Funeral director Clarence E. ArthurAddress Fork Md.19. April 17 19 48 C. E. Arthur

(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 48 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 47 to April 16 19 48
 and that I last saw him alive on April 15 19 48

Immediate cause of death Cerebral hemorrhage DURATION 2 months

Due to Arteriosclerotic heart

disease with hypertension

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jed O Hodous M. D. or otherAddress Edgewood Md Date signed 4-16-48

RECEIVED

APR 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH
 County Baltimore
 City or town 150 oak ave. Edgemere
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Edgemere, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 150 oak ave.
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Mary Lucinda Trisby

3. (b) Social Security Number

4. Sex F 5. Color or race Col 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Samuel Trisby
 8. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February - 1867
 8. AGE: Years 81 Months _____ Days _____ If less than one day _____ hrs. _____ min.

8. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business None
 12. Name Charles Ransom
 13. Birthplace Va.
 14. Maiden name Unknown
 15. Birthplace _____

16. Informant Coelia Hazel
 Address 150 oak ave. Edgemere MD
 17. Burial Date thereof 4/25/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Calvary Cem.
 Location A.A. County
 18. Funeral director Mrs. B. O. A. E. Lee, Jr. & Co.
 Address 1129 N. Caroline St.
 19. April 24 1948 G. W. Hedrick
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22nd 1948 at 5:05 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15th 1948 to April 22nd 1948
 and that I last saw her alive on April 22nd 1948
 Immediate cause of death Broncho pneumonia
 DURATION 10 days
 Due to Stenoplegia and
arterio-sclerosis 6 mo.
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE J. H. Thomas, M.D.
 M. D. or other _____
 Address Sumner St. Date 4/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03587

38

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since January 15, 1948Hospital, institution, or street address where death occurred:
Sheppard & Enoch Pratt Hospital, Towson, Md.How long in hospital or institution? Since January 15, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Fallston
(If outside city or town limits, write RURAL and give nearest town)Street No. None
(If rural, give LOCATION)2(a) If veteran, name war Spanish American - Army ✓

3. (a) FULL NAME

WILLIAM APELIUS GABLE

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Evelyn Briscoe Gable6. (c) If alive, give age Unk. years7. Birth date of deceased (mo., day, yr.) January 3, 18808. AGE: Years Months Days if less than one day
68 3 9hrs.min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Stone cutter

11. Industry or business

12. Name William Gable13. Birthplace Pennsylvania14. Maiden name Louise Thompson15. Birthplace Germany16. Informant Hospital records

Address

17. Burial Date thereof 4 / 15 / 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory U.S. NationalLocation Baltimore, Md.18. Funeral director William Cook Inc.Address 1217 St. Paul Street19. April 14, 1948 A. W. Hefner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 19 48 at 6:00 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 15 19 48 to April 12 19 48and that I last saw him alive on April 12 19 48Immediate cause of death chronicmyocardial infarctionDue to arteriosclerosis

Due to

Other conditions schizophrenia

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results confusion alone Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Nancy H. Wurdock, M.D. M. D. or otherAddress Sheppard-Pratt, Towson, Md. Date signed 4/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 303 Glenmore Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cora A. Gaither

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Herbert S. Gaither

7. Birth date of

deceased (mo., day, yr.)

January 31, 1898

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

5021

hrs.

min.

9. Birthplace

Poplar SpringsMd

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

FATHER

12. Name

John T. Pickatt

13. Birthplace

Md

MOTHER

14. Maiden name

Florence M. Dempsey

15. Birthplace

Md

16. Informant

Herbert S. Gaither

Address

Catonsville, Md

17.

Burial

Date thereof

4-6-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Poplar Springs

Location

Poplar Springs, Maryland

18. Funeral director

F. C. Higinbotham

Address

Ellicott City, Md.

19.

4/3

19

48

V. E. Harry

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 19 48 at 8.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 19 48 to April 2 19 48and that I last saw him alive on April 2 19 48

Immediate cause of death

Coronary Occlusion

DURATION

Sudden

Due to

Rheumatic Heart Disease

Due to

AcromioclavicularRheumatic Endocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Eliot W. Johnson

M. D. or other

Address

3432 Inverloch Ave

Date signed

RECEIVED

APR 5 1948

BUREAU. N. S.

TO: Mr. J. J. [unclear]

FROM: Mr. [unclear]

RE: [unclear]

DATE: [unclear]

BY: [unclear]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03589

Reg. Dist. No. 33

1. PLACE OF DEATH: Baltimore
 County.....
 City or town..... Reisterstown Route 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 yrs
 Hospital, institution, or street address where death occurred:
 Nicodemus Road Reisterstown Md
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland..... County..... Baltimore.....
 City or town..... Reisterstown Route 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Nicodemus Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

3. (a) FULL NAME William Lewis Gamber

3. (b) Social Security Number None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M
 6. (b) Name of husband or wife Ida Margaret Tillman
 Gamber 6. (c) If alive, give age 77 years
 7. Birth date of deceased (mo., day, yr.) July 26 1856
 8. AGE: Years 91 Months 8 Days 28 If less than one day
hrs.min.

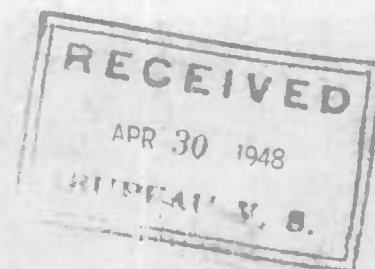
9. Birthplace..... Finksburg Carroll Co Md
 (Town, county, and state)
 10. Usual occupation..... Farm Worker
 11. Industry or business -
 12. Name William Snyder Gamber
 13. Birthplace Carroll Co Md
 14. Maiden name Annie R Haines
 15. Birthplace Finksburg Md

16. Informant Mrs William L Gamber
 Address Nicodemus Rd Reisterstown Md
 17. Burial Date thereof Apr 28 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Deer Park Cemetery
 Reisterstown Md
 Location Wm Berryman & Sons
 18. Funeral director Reisterstown Md
 Address
 19. 4-27-1948 Mary B. Eline
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24-48 at 11 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-30 to 4-24-48
 and that I last saw him alive on 4-23-48
 Immediate cause of death Myocardial chronic decomposition
 DURATION 5 yr
 Due to atherosclerosis
 Other conditions ✓
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op. -
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Mary B. Eline
 Address Reisterstown Md Date signed 4-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03590

Reg. Diat. No. 38

1. PLACE OF DEATH:

County BALTO
 City or town 607 CHUMLEIGH RD
 (If outside city or town limits, write RURAL and give nearest town)
ROGERS FORGE
 How long in above place of death? 1
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD. County BALTO
 City or town STONELEIGH
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 607 CHUMLEIGH RD
 (If rural, give LOCATION)
 2.(a) If veteran, name war N.

3. (a) FULL NAME

MARY ELIZABETH GERMAN

3. (b) Social Security Number

No

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JULY 1, 1870
 6.(c) If alive, give age _____ years

8. AGE: Years 77 Months 9 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace BALTO CO, MD.
 (Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

12. Name REG. I. GERMAN

13. Birthplace BALTO CO, MD.

14. Maiden name ELIZ. ANN. FOREMAN

15. Birthplace BALTO CO, MD.

16. Informant MR. WALTER J. HULL (BROTHER-IN-LAW)

Address 607 CHUMLEIGH RD.

17. (Burial, cremation, or removal, Which?) BURIAL Date thereof 4/30/48
 (month) (day) (year)

Cemetery or crematory DRUID RIDGE

Location PIKESVILLE, MD

18. Funeral director Wm. T. Tinkner & Sons

Address BALTO. MD

19. 4/30 19 48 D. W. Hedrick
 (Date registered by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 19 48 at 4:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 19 48 to April 27 19 48

and that I last saw her alive on April 27 19 48

Immediate cause of death Carcinoma of Uterus

Melanin to Bowel

Due to _____

Due to _____

Other conditions Obstruction of large Bowel

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. C. Cook M. D. M. D. or other

Address 6805 York Road Date signed 4/28/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03591

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
322 Main St Reisterstown Md
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Baltimore
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 322 Main St
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME

Sarah Elizabeth Baublitz Gill

3.(b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M

6.(b) Name of husband or wife Harvey Gill

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) October 22 1883

8. AGE: Years 64 Months 5 Days 3 If less than one day hrs. min.

9. Birthplace Chestnut Ridge Balto Co Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business -

12. Name Jacob Baublitz

13. Birthplace Chestnut Ridge Md

14. Maiden name Elizabeth Phillis

15. Birthplace Baltimore Co Md

16. Informant Mrs Helen L Kerchner

Address 6017 Falls Road Balto Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof April 28 1948
(month) (day) (year)

Cemetery or crematory Druid Ridge Cemetery

Location Pikesville Md

18. Funeral director Wm Berryman & Sons

Address Reisterstown Md

19. 4-27- 19 48 Mary B. E. Hine
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26-48 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-24-48 to 4-26-48 and that I last saw him alive on 4-25-48

Immediate cause of death myocarditis
chronic degenerative

Due to birth of liver

Other conditions ✓
(Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op. ✓

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE J. L. Saffel M. D. or other

Address Reisterstown Md Date signed 4-26-48

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
APR 30 1948
BUREAU V 8.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03592

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 175 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, F. Howard, Maryland
How long in hospital or institution? 175 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 728 Ramsey Street
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

JOHN F. GORMAN

3. (b) Social Security Number

217-05-3426

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar 5, 1920

8. AGE: Years 28 Months 1 Days 10 It less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Counter Man

11. Industry or business _____

12. Name Thomas Gorman

13. Birthplace Ireland

14. Maiden name Margaret BAHEN

15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof Apr 19, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadowridge

Location Jessups Md

18. Funeral director Mrs. Mrs. J. W. Teufel & Son

Address 5311 Edmondson Ave

19. April 17, 1948 Registrar A. N. H. H. H.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1948 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23, 1947 to April 15, 1948
and that I last saw him alive on April 15, 1948

Immediate cause of death Intravenous injection of diodrast DURATION Sudden

Due to _____

Due to _____

Other conditions Unexplained pulmonary hypertension; extreme hypertrophy of right heart; pulmonary arteriosclerosis Approx. 5 Yrs.

Major findings of operations _____

_____ Date of op. _____

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide accident Date of April 15, 1948

Where did injury occur? Hospital - Baltimore Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Hospital

Means of injury injection of diodrast Injured at work? no

23. SIGNATURE [Signature] M. D. or other _____

Address Det. Harb. Ft. Howard Date signed Apr 16, 1948

Harold J. McAdams, M.D.

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

03593

38

1. PLACE OF DEATH:

County Baltimore County
 City or town Butler, Sparks, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Glenarm
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HARRY BONFIELD GORRELL

3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife Rose Virginia Gorrell

7. Birth date of deceased (mo., day, yr.) October 4, 1869
 6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

78

5

26

hrs.

min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Robert B. Gorrell13. Birthplace Maryland14. Maiden name Mary E. Works15. Birthplace Maryland16. Informant Mrs. Virginia KesslerAddress Falls Rd. Butler, Md.

17. Burial Date thereof 4/5/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine Park Cemetery
Baltimore, Md.

Location HENRY SANDER & SONS, INC
NORTH AVE. & BROADWAY

18. Funeral director HENRY SANDER & SONS, INC
 Address NORTH AVE. & BROADWAY

19. April 5 48 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1948 at 2.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 24 48 to April 2 48
 and that I last saw him alive on April 1 48

Immediate cause of death

Carcinoma of
Lung

DURATION

6 mo.

Due to

Due to

Other conditions

Arterio-sclerotic
Heart Disease
 (Include pregnancy within 3 months of death)

3 yrs

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maurice C. Porterfield
Lanpoten Md.
 Address Date signed 4-3-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03594

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town Cedar Crest
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs.
 Hospital, institution, or street address where death occurred:
none 60 Murdock Road
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Cedar Crest
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 60 Murdock Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

GRINNELL, Milton W.

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Mary Florace Menendez
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) February 15, 1890
 8. AGE: Years 58 Months 1 Days 23 If less than one day hrs. min.

8. Birthplace Maine
 (Town, county, and state)
 10. Usual occupation Field Engineer
 11. Industry or business Federal Communications
 12. Name Bela A. Williston Grinnell
 13. Birthplace Washington, Maine
 14. Maiden name Sarah E. Rose
 15. Birthplace Washington, Maine
 16. Informant Mrs. Mary M. Grinnell
 Address 60 Murdock Road

17. Burial Date thereof April 10, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory
 Location Buffalo, N. Y.
 18. Funeral director John O. Mitchell & Sons, Inc.
 Address 1900 Eutaw Place

19. April 8, 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1948 at 2:00 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to April 7, 1948
 and that I last saw him alive on April 7, 1948
 Immediate cause of death Coronary occlusion
 Due to Coronary arteriosclerosis
 Due to
 Other conditions none
 (Include pregnancy within 8 months of death)

DURATION

1 hour
1 year

Major findings of operations none Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE A. S. Chayant M. D. or other
 Address 6210 York Rd Date signed April 7, 1948

MAY 6 116 MAY 27 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

926

03595

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County Elba Md.City or town Baltimore Co.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sarah Miranda Hall

3. (b) Social Security Number

4. Sex

F.

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

unknown

7. Birth date of

deceased (mo., day, yr.)

JAN. 15 1858

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8990222

hrs.

min.

9. Birthplace

Calonsville Md.

(Town, county, and state)

10. Usual occupation

unemployed.

11. Industry or business

MOTHER

FATHER

12. Name

Herzkeiah Henderson

13. Birthplace

Md.

14. Maiden name

Sarah Solding

15. Birthplace

Md.

16. Informant

James Blainford

Address

414 - O'Calla Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

4/11/48

Cemetery or crematory

Halls Family Cemetery

Location

Calonsville, Md.

18. Funeral director

Address

918 - Almond Hill

19.

4-10-48
(Date rec'd by registrar)

19.

Dr. A. W. [illegible]

Regist.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

O'Calla

(If outside city or town limits, write RURAL and give nearest town)

Street No.

414 - O'Calla Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

4-7-48

19.

11.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-13-47

19.

to

4-7-48

and that I last saw her alive on

4-7-48

19.

Immediate cause of death

DURATION

Mitral Insufficiency

Due to

Sen. Arterio-sclerosis

Due to

Other conditions

Spontaneous ulceration of spine (Pott's), due
(Include pregnancy within 3 months of death) resulting from pressure to bed sores
(5/25/48)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. F. Maloney MD

M. D. or other

Address

Calonsville Md.

Date signed

4/7/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03596

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH: **Baltimore**County **Arbutus**
City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
4130 Wilkens Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State **Md.** County **Baltimore**City or town **Arbutus**
(If outside city or town limits, write RURAL and give nearest town)Street No. **4130 Wilkens Ave.**
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louisa Schleifer Hanft

3. (b) Social Security Number

4. Sex **Female** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Widowed**6.(b) Name of husband or wife **Theodore M.**6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) **October 1, 1863**8. AGE: Years **84** Months **6** Days **8** If less than one day
.....hrs.min.9. Birthplace **Nashville Ill.**
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name **Ferdinand Schleifer**
13. Birthplace **Germany**MOTHER 14. Maiden name **Kaltenbach**
15. Birthplace **Germany**16. Informant **Mrs. Gertrude H. Walmer**
Address **4130 Wilkens**17. **Removal** Date thereof **4/9/48**
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory **Washington D.C.**

Location

18. Funeral director **Wm. R.F. Hines**
Address **2901 14th St. Washington D.C.**19. **April 9, 1948** **A. W. Hedrick**
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **4-9-** **48** at **1:30** P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **April** 19 **45**, to **April 9** 19 **48**
and that I last saw her alive on **April 9, 1948**Immediate cause of death **arterosclerotic myocarditis** DURATION **1 yr.**Due to **Generalized arterosclerosis**Due to **Age**

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **M. B. Schleifer M.D.** M. D. or otherAddress **544 D. Fulton Ave** Date signed **4-9-48**

Dr. Morris B. Schrieber
3506 Ellament St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3801 S. Hanover Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war SAW ✓

3. (a) FULL NAME

SAMUEL B. HARRISON

3. (b) Social Security Number

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Widower	
6. (b) Name of husband or wife <u>Widower</u>			
7. Birth date of deceased (mo., day, yr.) <u>11-3-1880</u>			
8. AGE: Years 67	Months 5	Days 25	If less than one day hrs. min.
9. Birthplace <u>Baltimore, Maryland</u> (Town, county, and state)			
10. Usual occupation <u>Unemployed</u>			
11. Industry or business			
12. Name <u>Samuel Harrison</u>			
13. Birthplace <u>Maryland</u>			
14. Maiden name <u>Mary Ann Simmons</u>			
15. Birthplace <u>Maryland</u>			

16. Informant Clinical Records, Vets. Adm. Hosp.
Fort Howard, Maryland
 Address _____

17. Burial Date thereof May 1-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory United States Natl Cem.
 Location Fredrick Rd Balto. Md
Milton Schilling

18. Funeral director 3914 Hanover St 25
 Address _____

19. April 28 19 48 Ida M. Whitens
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 19 48, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 26, 19 48, to April 28, 19 48.....
 and that I last saw him alive on April 28, 19 48.....
 Immediate cause of death
Myocardial infarction
 DURATION 3 days
 Due to Coronary Occlusion 3 days
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:
 Accident, suicide, or homicide, Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE H. C. MANAUGH
H.C. MANAUGH, M. D. Chief Professional
VAH, Ft. Howard, Md. Ser. 4-28-48
 Address Date signed 4-28-48

RECEIVED

APR 30 1918

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03598

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Susie E. C. Frederick

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (n) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 6/13/19598. AGE: Years 88 Months 10 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Ellicott City, Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name William Barrett13. Birthplace Maryland14. Maiden name Mary Dock15. Birthplace Maryland18. Informant Mrs. Frank T. PiraroAddress 109 Coburn Ave17. Burial Date thereof Apr 20-48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Landon ParkLocation Catonsville, Maryland18. Funeral director F. B. Whippert & SonAddress 1300 Eastway Place19. 4-20-48 Chas. W. E. Fisher
(Date rec'd by registrar) (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 109 Coburn Ave
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1948 at 9:30 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1948 to April 16, 1948and that I last saw him alive on 4/16/48Immediate cause of death Cerebral Thrombosis DURATION 42 yrsArterial Sclerosis 10 yrs

Due to _____

Due to _____

Other conditions Pulmonary Embolism 1 week

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Chas. W. E. Fisher M. D. or other _____Address 2145 N. Balto St. Date signed 4/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

03599

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 611 Orspington Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cora V. Hennemann

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white Widow6. (b) Name of husband or wife Edwin G. Hennemann

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 6, 18728. AGE: Years 76 Months 3 Days 22 It less than one day _____ hrs. _____ min.9. Birthplace Baltimore
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business

12. Name John Walstrum13. Birthplace Md.14. Maiden name Eliza Frederick15. Birthplace Md.16. Informant George L. HennemannAddress 611 Orspington Road17. Burial Date thereof May 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WesternLocation City18. Funeral director Mr. & Mrs. John W. Tengel & SonAddress 5311 Edmondson Ave19. April 30 19 48 A. W. Hedrick
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 28 19 48 at 5:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1937 19 1937, to April 28 19 48
and that I last saw him alive on 4/28 19 48Immediate cause of death Cerebral HemorrhageDURATION 52 hrs.Due to Arteriosclerotic Cardiovascular Disease

Due to

Other conditions Sensibility

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Deane Laughlin M. D. or otherAddress 400 N. Payson St. Date signed 4/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age
shown on:

FILM No. G 116 JUN 2 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03600

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH: Marphila Henson
County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Watto
City or town Germantown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 N. Main St. Dundock 22
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Marphila Henson

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife John
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Dec 23, 1887 (1887)
8. AGE: Years 60 Months _____ Days _____ If less than one day _____ hrs. _____ min.
9. Birthplace Annapolis County Md
(Town, county, and state)
10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace _____
MOTHER 14. Maiden name Sarah
15. Birthplace N.C.

16. Informant Peter Clark
Address 101 Main St
17. Burial Date thereof April 4 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory mt Calvary Cem
Location Ad County Md
18. Funeral director Mr R. H. Edwards
Address 1129 N. Center St

19. April 7, 1948 a. w. Edwards
(Date signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1948 at 7:15 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30th 1948 to April 6th 1948
and that I last saw him alive on April 6th 1948
Immediate cause of death Cerebral apoplexy DURATION 7 days
Due to arteriosclerosis
Due to _____
Other conditions _____
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. Thomas MD
Address Germantown Date signed 4/6/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03601 30
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore 24 Dutton Avenue

City or town Catonsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 Dutton Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ARTHUR CAMPBELL HERD

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Amelia Tess

7. Birth date of deceased (mo., day, yr.) April 23, 1912 6.(c) If alive, give age 29 years

8. AGE: Years 36 Months 0 Days 5 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Aupt.

11. Industry or business Robert C. Herd & Co.

12. Name Robert C. Herd
13. Birthplace Scotland

14. Maiden name Lillian M. George
15. Birthplace Baltimore, Maryland

16. Informant Wife
Address 24 Dutton Avenue

17. Burial Date thereof May 1, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Louden Park Cemetary
Location Frederick Road

18. Funeral director L. Heemann & Son
Address 6067 Harford Road

19. 4/30 19 48 Arthur Campbell Herd Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1948 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7, 1947 to April 28, 1948 and that I last saw him alive on April 28, 1948 Immediate cause of death cardiac failure

	DURATION
Due to <u>pulmonary embolism</u> <u>mitral stenosis</u>	<u>4 wks.</u>
Due to <u>rheumatic heart disease</u>	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Injured at work?
Means of injury

23. SIGNATURE George A. Kuypas M.D. M. D. or other
Address 3030 Edmondson Ave. Date signed 4/29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

WITH UNFADING INK. Supply every item of information, fully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Balto
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

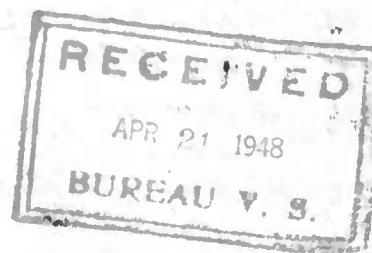
Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03603

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution? 35 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1710 W. Lanvale Street
(If rural, give LOCATION)
2.(a) If veteran, name war WW-2 ✓

3. (a) FULL NAME

HARRY H. HILLERY

3. (b) Social Security Number

216-01-1243

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mary Hillery
6.(c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) 12-25-1902
8. AGE: Years 45 Months 3 Days 18 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1948 at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9, 1948 to April 13, 1948 and that I last saw him alive on April 13, 1948

Immediate cause of death Peritonitis DURATION Unknown

Due to Carcinoma of Stomach with perforation 4 weeks plus

Due to _____
Other conditions Metastases to Regional lymph nodes and liver Unknown
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Laundry Worker
11. Industry or business _____
12. Name Thomas Hillery
13. Birthplace Washington, D. C.
14. Maiden name Rebecca Clark
15. Birthplace Rhode Island
16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial Date thereof 4-17-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
Location _____
18. Funeral director Thomas Kelson
Address Baltimore, Md.
19. 4/15 x 0 A-W Hedrick
(Date rec'd by registrar) (Signature) (Registrar)

23. SIGNATURE H.C. MANAUGH
H.C. MANAUGH, M.D. Chief Professional
Address VAH, Ft. Howard, Md. Ser. signed 4-14-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

13277 Rolling Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County _____City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)Street No. 2049 Braddish Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Ida Hoffman

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female W. Widow

6. (b) Name of husband or wife Late John Hoffman

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mich. 31, 1858.

8. AGE: Years Months Days If less than one day
90 0 10 _____ hrs. _____ min.

9. Birthplace md.
 (Town, county, and state)10. Usual occupation None

11. Industry or business _____

12. Name Henry E. Bloom13. Birthplace md14. Maiden name Unknown15. Birthplace md.16. Informant Mrs. Edward AyndAddress 2825 Windsor Ave17. Burial Date thereof Apr. 12/48.
 (Burial, cremation, or removal. When) (month) (day) (year)Cemetery or crematory Randon Pk.Location 3801 Frederick Rd.18. Funeral director Harry F. WitzkeAddress 4101 Edmondson Ave19. April 11 19 48 VB Harvey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10/48. 19____, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7 19____, to April 9 19____and that I last saw him/her alive on April 9/48 19____

Immediate cause of death _____ DURATION

Cardiac failure 1 dayDue to Bronchopneumonia 2 days(hypostatic)Due to Cerebral hemorrhage one weekOther conditions Arteriosclerosis, generalizedSeizure

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. H. Williamson M.D.Address 3225 Frederick Ave Date signed 4/10/48Baltimore

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **03605** **XX**

1. PLACE OF DEATH:

County **Baltimore**City or town **Fort Howard**
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? **Approximately 3 Hrs.**

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? **Approximately 3 Hrs.**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** CountyCity or town **Baltimore**
(If outside city or town limits, write RURAL and give nearest town)Street No. **103 N. Schroeder Street**
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MARK HOLLMAN

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife **Laura B. Hollman**

6. (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) **? 1909**8. AGE: Years **39** Months Days If less than one day
..... hrs. min.9. Birthplace **?**
(Town, county, and state)10. Usual occupation **?**

11. Industry or business

12. Name **Preston Hollman**13. Birthplace **?**14. Maiden name **Charlotte ?**15. Birthplace **?**16. Informant **Clinical Records, Vets. Adm. Hospital**Address **Fort Howard, Maryland**17. **Burial** Date thereof **4/27/48**
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory **Eastview**Location **Petersburg, Va.**18. Funeral director **Elroy O. Wilson**Address **1000 Brantley Ave., Baltimore, Md.**19. **X** 19 **XX DP** Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **April 20,** 19 **48** at **10:30 P.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 20, 19 **48** to **April 20,** 19 **48**and that I last saw him alive on **April 20,** 19 **48**Immediate cause of death **Nephritis, chronic**
Cause, Unknown DURATION **Unknown**

Due to

Due to

Other conditions **Cardiac Dilatation &**
Hypertrophy **Unknown**
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results **Substantiated above.**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Deputy Medical Examiner** M. D. or otherAddress **Balto., Co., Dundalk 22, Md.** Date signed **4-21-48**

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

03606

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 years, 11 months, 21 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 19 years, 11 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Robert L. Hopkins

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Married</u>

6. (b) Name of husband or wife Ethel M. Hughes7. Birth date of deceased (mo., day, yr.) June 6 18918. AGE: Years Months Days If less than one day
56 10 3 hrs. min.9. Birthplace Harford County
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Agricultural12. Name William J. Hopkins13. Birthplace Maryland14. Maiden name Ida Forsythe15. Birthplace Maryland16. Informant Hospital records

Address _____

17. Burial Date thereof Apr. 13, 1948
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory Rock RunLocation Harford Co. Md.18. Funeral director Modern MortuaryAddress Havre de Grace, Md.19. 4/10/48 19. W.E. Harry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1948 19. at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 30 1928 19. April 9 19. 48and that I last saw him alive on April 9 1948 19. 48Immediate cause of death Myocardial failureDURATION 6 days

Coronary sclerosis Indefinite

Due to Arteriosclerotic Heart Disease "

Generalized arteriosclerosis "

Due to Hypertensive cardiovascular "

renal disease "

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

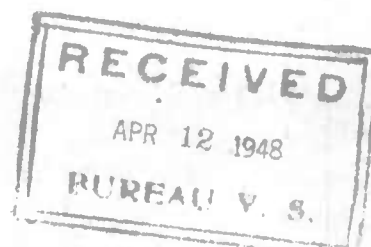
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature Isadore Tuerk23. SIGNATURE Isadore Tuerk, M. D.Address Catonsville, 28, Md. Date signed 4/10/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

CERTIFICATE OF DEATH

Reg. Dist. No. 03607

1. PLACE OF DEATH: BaltimoreCounty DundalkCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 240 Curlew Court

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Robert Heath Horne

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

SeparatedBeatrice N. Horne

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

May 22, 1918

8. AGE:

Years

Months

Days

If less than one day

29115

hrs.

min.

9. Birthplace

Monroe, N. C.

(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

FATHER

12. Name

Dock HorneN.C.

13. Birthplace

MOTHER

14. Maiden name

Carry McCainN.C.

15. Birthplace

16. Informant

Sallie Horne

Address

240 Curlew Court

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

4/30/48

(month) (day) (year)

Cemetery or crematory

Baltimore National

Location

Irvington, Md.

18. Funeral director

Elroy O. Wilson

Address

1000 Grantly Ave.

19.

(Date rec'd by registrar)

19 4/3019 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 2719 48at 11:50

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Gun shot wound thru
Right Temporal -

DURATION

=

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Suicide

Date of

4/27/48

Where did injury occur?

TURNER ST. - BALTIMORE, MD.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Public Place

Means of injury

Shot Self - 38 cal. Pistol

Injured at work?

No

23. SIGNATURE

Address

Date signed

4/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03608

31

1. PLACE OF DEATH:

County

BALTO.

City or town

WOODLAWN - 6432 GILMORE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 YRS.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD

County

BALTO

City or town

WOODLAWN

(If outside city or town limits, write RURAL and give nearest town)

Street No.

6432 GILMORE ST

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

JOHN HARVEY HOWARD

3. (b) Social Security Number

No

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

ELLA H. HOWARD

7. Birth date of deceased (mo., day, yr.)

SEPT. 26, 1968

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

79

7

1

hrs.

min.

9. Birthplace

BALTO Co. MD.

(Town, county, and state)

10. Usual occupation

RETIRED - [P.R.R. (BYO)]

11. Industry or business

FATHER

12. Name

CORNELIUS H. HOWARD

13. Birthplace

BALTIMORE MD.

MOTHER

14. Maiden name

ANNIE E. WARMS

15. Birthplace

MONTGOMERY Co., MD.

16. Informant

MRS. ELLA H. HOWARD

Address

6432 GILMORE ST.

17.

(Burial, cremation, or removal, Which?)

Date thereof

4/30/48

Cemetery or

Mt. OLIVE

Location

RANDALLSTOWN, MD

18. Funeral director

WM. J. TICKNER & SONS

Address

BALTO. MD.

19.

(Date rec'd by registrar)

4/29 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

4/27

19

48 at 3 45 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov

19

48

to

4-27

19

and that I last saw him alive on

4/26/48

Immediate cause of death

Uremic poison

Chronic Nephritis

DURATION

Due to

Acute secondary anemia

Due to

Generalized arteriosclerosis

Other conditions

Malnutrition

None removed from the removal of other

set (history) had extensive bleeding

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. G. Abbott M.D.

M. D. or other

Address

4509 Liberty Key Rd

Date signed

4-28

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore - Zone # 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1133 Down St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-1 ✓

3.(a) FULL NAME

PATRICK P. HUNT

3.(b) Social Security Number

267-05-8695

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife deceased
 7. Birth date of deceased (mo., day, yr.) 11-24-94 6.(c) If alive, give age _____ years
 8. AGE: Years 53 Months 4 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Auburn, Alabama
 (Town, county, and state)
 10. Usual occupation unemployed
 11. Industry or business _____

FATHER 12. Name Jake Hunt
 13. Birthplace Alabama
 MOTHER 14. Maiden name Emma Lengrade
 15. Birthplace Alabama

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof 4-20-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
 Location _____

18. Funeral director Charles R. Law
 Address 802 Madison Ave., Baltimore, Md.

19. April 19 19 48 R. W. [Signature]
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 48 at 12:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 9 19 48 to April 17 19 48
 and that I last saw him alive on April 17 19 48

Immediate cause of death Cerebral Thrombosis DURATION Unknown

Due to Hypertensive cardio-vascular disease Unknown

Due to _____
 Other conditions Carcinoma of cecum with metastasis to regional lymph nodes Unknown
 (Include pregnancy within 3 months of death)

Major findings of operations Resection of cecum for Carcinoma; Appendectomy Date of op. 4-16-48; 4-9-48

Autopsy results No Autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature]
H.C. MANAUGH, M.D. Chief Professional Ser.
VAH, Ft. Howard, Md. Date signed 4-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Called Ft Howard for verification of Street

They gave me Zone 1.

ams - 5/7/68

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Baltimore
City or town Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo. 15 Days
Hospital, institution, or street address where death occurred:
Baltimore County Home
How long in hospital or institution? 4 mo. 15 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Huser

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Agusta Shooter
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar. 4 - 1850

8. AGE: Years 98 Months 0 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Texas Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Fred Wright Whitman

13. Birthplace _____

14. Maiden name Frances Huser

15. Birthplace _____

16. Informant Baltimore County Home Registrar

Address Texas Maryland

17. Burial Date thereof Apr. 17 - 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory _____

Location Cockeysville, Maryland

18. Funeral director Landon - M. Brooks

Address Sparks - Md.

19. 4/15 19 48 Wm J. Chilcoat
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 19 48 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 47 to 4/15 19 48
and that I last saw him alive on 4/14 19 48

Immediate cause of death Carcinoma -
(Prostate)

Due to Senility
Due to Arterio sclerosis

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) (County) (State)

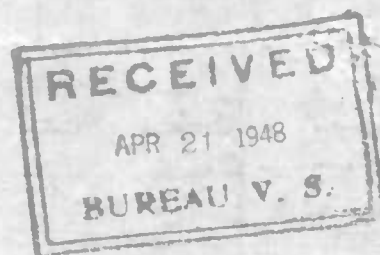
Injured at home, farm, industry, public place (where?) _____
Means of Injury _____ Injured at work? _____

23. SIGNATURE Wilmer C. Ensor M.D.
Address Cockeysville Md. Date signed 4/15/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PL. WITH UNFADING INK. Supply every item of information, especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03611

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore-12
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 812 Register Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name War

3. (a) FULL NAME

Claudia Hutchins

3. (b) Social Security Number

None

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Walter 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1868?
 8. AGE: Years 80? Months ? Days ? If less than one day _____ hrs. _____ min.
 9. Birthplace Balto Co., Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business ?
 12. Name Wm. Buice
 13. Birthplace Balto Co. Md.
 14. Maiden name Mildred Curtis
 15. Birthplace Balto Co. Md.

16. Informant Hospital records
 Address Catonsville-28, Md.
 17. Burial Date thereof Apr. 4, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Clymmalura
 Location Mohrston, Md.
 18. Funeral director Samuel M. Burch
 Address Sparks, Md.
 19. April 2, 1948 V.E. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1948 at 7:10 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 1948 to April 2, 1948
 and that I last saw her alive on April 2, 1948
 Immediate cause of death Coronary sclerosis DURATION indefinite
 Due to Generalized arteriosclerosis
 Due to Arteriosclerotic heart disease with atricular fibrillation
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury Gunshot Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____
 Address Catonsville-28, Md. Date signed 4-2-48

RECEIVED

APR 5 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 30

03612

1. PLACE OF DEATH:

County.....**Baltimore**
City or town.....**Oella Ave. Oella, Md.**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....**47 years**
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....**Maryland** County.....**Baltimore**
City or town.....**Oella**
(If outside city or town limits, write RURAL and give nearest town)
Street No.....**Oella Avenue**
(If rural, give LOCATION)
2.(a) If veteran, name war.....**None**

3. (a) FULL NAME

HARRIET (HATTIE) ELIZA IGLEHART

3. (b) Social Security Number

None

4. Sex.....**Female** 5. Color or race.....**White** 6.(a) Single, married, widowed, or divorced.....**Widowed**

6.(b) Name of husband or wife.....**Leonidas Iglehart**

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.).....**July 23, 1862.**

8. AGE: Years.....**85** Months.....**9** Days.....**0** If less than one day.....hrs. min.

9. Birthplace.....**Howard County, Maryland.**
(Town, county, and state)

10. Usual occupation.....**Housewife**

11. Industry or business.....

12. Name.....**Jesse Severn**

13. Birthplace.....**Montgomery County, Maryland.**

14. Maiden name.....**Mary Shipley**

15. Birthplace.....**Maryland.**

16. Informant.....**Miss Edna Iglehart**

Address.....**Oella Avenue, Oella, Maryland.**

17. Burial..... Date thereof.....**April 26, 1948.**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....**Good Shepherd Cemetery**

Location.....**Rockland, Maryland.**

18. Funeral director.....**Easton Sons**

Address.....**Ellicott City, Maryland.**

19. **April 25** 19**48** **T.E. Harry**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**April 23** 19**48** at **5:00** P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **May** 19**40** to **April 23** 19**48** and that I last saw him alive on **April 23** 19**48**

Immediate cause of death.....**Arteriosclerotic heart disease**

DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

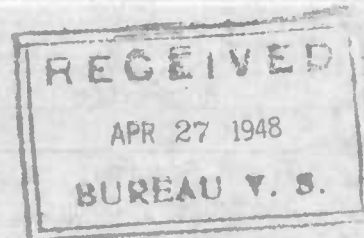
23. SIGNATURE.....**Jess P. Kochman MD**
M. D. or other

Address.....**Ellicott City, Md** Date signed.....**4/24/48**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94-01

03613

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address where death occurred:
7 Payson Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 Payson Ave.
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME

Florence H. Dwing

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife L. M. Dwing

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1872 6. (c) If alive, give age 75 years

8. AGE: Years 75 Months 6 Days 13 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Thomas Dennis

12. Name Maryland

13. Birthplace Blick Abell

14. Maiden name Maryland

15. Birthplace Mrs. J. B. Hunt

16. Informant 7 Payson Ave. Catonsville

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Apr 6, 1948
(month) (day) (year)

Cemetery or crematory London Park

Location Frederick Ave. Catonsville

16. Funeral director Easton Sons

Address 608 Frederick Ave. Catonsville, Md.

19. April 6, 1948 V. E. Harry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 3, 1948 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 1946 to APRIL 3, 1948

and that I last saw ER alive on MARCH 1948

Immediate cause of death Coronary Arteriosclerosis DURATION 1 1/2 yrs

Due to Coronary Insufficiency 10 yrs.

Due to Atherosclerosis 1 yr.

Other conditions General Senility

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury None Injured at work? None

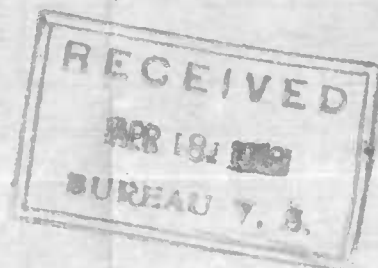
23. SIGNATURE J. H. Williams, M.D.

Address 3325 Frederick Ave. Baltimore Date signed 4/5/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

03614

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 44 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 44 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1733 Lancaster Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-2 ✓

3. (a) FULL NAME

CHARLES F. JOHNSON

3. (b) Social Security Number

2-18-22-4607
Unknown

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Iona Johnson
 6.(c) If alive, give age 2 years
 7. Birth date of deceased (mo., day, yr.) 6-24-01
 8. AGE: Years 46 Months 9 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business _____
 12. Name John Johnson
 13. Birthplace Baltimore, Maryland
 14. Maiden name Catherine Anderson
 15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. A.m. Hosp.
 Address Fort Howard, Md.
 17. Burial Date thereof 4/19/48
 (Burial, cremation, or removal? Which?) Baltimore National Cemetery
 Cemetery or crematory Baltimore, Maryland
 Location Howard N. Blight Jr.
 18. Funeral director Howard Blight, Jr.
 Address 4914 Belair Rd., Baltimore, Md.

19. April 19, 1948 C. W. Hedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 19 48, at 8:35 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 19 48, to April 16, 19 48,
 and that I last saw him alive on April 16, 19 48
 Immediate cause of death SUBACUTE NEPHRITIS

DURATION
Unknown

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results Substantiated Above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE W. H. Henningsen M.D. M. D. or other
 Address VAH Fort Howard, Md. Date signed 4-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 57

03615

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

48

Wilmer C. Ensor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 48 at 5:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 47 to April 19 48

and that I last saw him/her alive on April 16 19 48

Immediate cause of death

Arteriosclerotic heart disease

Due to

Due to

Other conditions

Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Elizabeth B. Stenhill, M.D.

M. D. or other

Address

Cockeysville, Md.

Date signed 4-16-48

RECEIVED
APR 20 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

03616

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore

City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No. Garrison Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rachel A. Kneller

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife Edward D. Kneller

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1869

8. AGE: Years Months Days If less than one day
78 8 18 hrs. min.

9. Birthplace Carroll Co.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Peter Wisner

13. Birthplace Md.

14. Maiden name Sophie Beckley

15. Birthplace Md.

16. Informant Mr. Claude W. Kneller

Address Owings Mills, Md.

17. Burial Date thereof April 20, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Balto. Co.

18. Funeral director J.F. Eline & Sons

Address Reisterstown, Md.

19. 4-19- 1948 Dr. E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9- 1948, to Apr 17 1948

and that I last saw him alive on Apr 16 1948

Immediate cause of death

Arterial thrombosis 8 days

Due to arterio sclerosis ?

Due to arterial by rupture ?

Other conditions chronic

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. E. Nichols M.D.

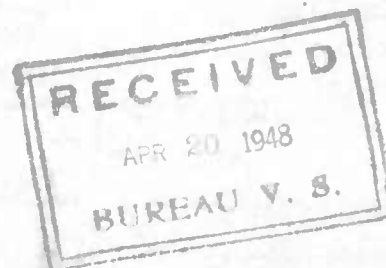
Address Pikesville, Md. Date signed 4/19/48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 939

03617

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto

City or town Victory Villa
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

31 Selfridge Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Victory Villa
(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 Selfridge
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Solomon Koons

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 14 - 1869

8. AGE:

Years 78

Months 7

Days 20

It less than one day

hrs. min.

9. Birthplace

York Co. Penna
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER
FATHER

12. Name

Amos Koons

13. Birthplace

York Co. Pa.

14. Maiden name

Mary Jane Koons

15. Birthplace

York Co. Penna

16. Informant

Mr. Harry F. Long

Address

31 Selfridge Rd

17.

(Burial, cremation, or removal, which?)

Date thereof

4-8-48
(month) (day) (year)

Cemetery or crematory

Salem Cemetery

Location

Penna.

16. Funeral director

Henry F. Burg

Address

131 W. Broadway Phila. Pa.

19.

4-5-48
(Date rec'd by registrar)

19.

John S. Connelley
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 1948 to April 4 1948

and that I last saw him alive on April 4 1948

Immediate cause of death

Coronary Thrombosis

DURATION

Sudden

Due to

Arterio-Sclerotic

Cardio-vascular disease 2 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. M. Brown Gardner
Balto 6 Md
Date signed 4-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03618

Reg. Dist. No. 44

1. PLACE OF DEATH

County BaltimoreCity or town Sparrows Point Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

624 E. St.

How long in hospital or institution?

3. (a) FULL NAME

Charles Koppke

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Bertha V. Koppke

7. Birth date of

deceased (mo., day, yr.)

Oct. 16, 1896

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

51614

hrs.

min.

9. Birthplace

Czechoslovakia
(Town, county, and state)

10. Usual occupation

Crane Operator

11. Industry or business

Bethlehem Steel Co.

MOTHER

12. Name

Charles Koppke

13. Birthplace

Cyprus, Hungary

14. Maiden name

Maria Koppke

15. Birthplace

Unknown

16. Informant

Bertha V. Koppke (wife)

Address

624 E. St. Sparrows Pt. Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Cabtown

Location

Eastern Ave.

18. Funeral director

Address

Wm. Cook Inc.
1217 St. Paul St.

19.

(Date rec'd by registrar)

May 31948C. W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Rural Sparrows Point Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

624 E. St.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 30

19

48 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 20 1948 to April 30 1948
and that I last saw him alive on April 29 1948

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. Cook Inc.
520 D St. Spt 15

M. D. or other

Date signed

4-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 4 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 Now long in hospital or institution? 2 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Baltimore City Hospital
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Antonio Lauletta

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife ?
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1876?
 8. AGE: Years 72 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace ?
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business ?
 12. Name ? Lauletta
 13. Birthplace ?
 14. Maiden name ?
 15. Birthplace ?

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof 6-29-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Spring Grove Hospital
 Location Catonsville 28 md
 18. Funeral director Spring Grove Hospital
 Address Catonsville 28 md
 19. 6-29 19 48 V.E. Harris
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 48 at 12:25p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 19 48 to April 7 19 48 and that I last saw him alive on April 7 19 48

Immediate cause of death Gangrene, fourth toe, right foot DURATION 5 days

Due to Arteriosclerotic heart disease indefinite

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature Isadore Tuerk
Isadore Tuerk, M.D.
 23. SIGNATURE _____ M. D. or other _____

Address Catonsville-28, Md. Date signed 6-28-48

RECEIVED

JUL 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03620

42

1. PLACE OF DEATH:

County BALTIMORECity or town LANS DOWNE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTIMORECity or town LANS DOWNE
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 HILLSDALE RD
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MAUDE E LAWSON

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

WIDOW6.(b) Name of husband or wife JOE HARTLEY LAWSON

7. Birth date of

deceased (mo., day, yr.) NOV. 30, 1875

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

72415

hrs.

min.

9. Birthplace

CANADA

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

WILLIAM SIMMONS SIMMONS

13. Birthplace

CANADA

14. Maiden name

15. Birthplace

CANADA

16. Informant

MRS MAUDE IRISH

Address

200 HILLSDALE RD17. REMOVAL

(Burial, cremation, or removal, Which?)

Date thereof

APRIL 15 '48

(month) (day) (year)

Cemetery or crematory

Location EAST PEPPERBALL - MASS.

18. Funeral director

Harry H. Witzke

Address

4101 Elmwood Ave19. 4/15

(Date reg'd by registrar)

19. XPD.W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 15 19 48 at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/20/47

19

to 4/15/48

19

and that I last saw him alive on 4/14/48

19

Immediate cause of death Arteriosclerotic
Cardio Vascular Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

M. D. or other

Address

2441 Washington Blvd

Date signed

4/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03621

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 40 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2641 Edmondson Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I ✓

3. (a) FULL NAME

FRANK M. LENZ

3. (b) Social Security Number

215-10-4732

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 3-19-90 6. (c) If alive, give age _____ years

8. AGE: Years 58 Months 1 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Guard

11. Industry or business _____

12. Name John H. Lenz13. Birthplace Baltimore, Maryland14. Maiden name Emma M. Vogel15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. BURIAL Date thereof MAY 13 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory ST PAULS CEM

Location VIOLETSVILLE MD

18. Funeral director MRS Chas. G. & Rohde

Address 121 E. 7th St.
2327 EDMONDSON AVE

19. X/30 19 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 19 48 at 4:55 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20, 19 48 to April 29, 19 48
 and that I last saw him alive on April 29, 19 48

Immediate cause of death Acute Hemorrhage DURATION 5 Hrs.

Due to Rupture of Esophageal varix 5 Hrs.

Due to Cirrhosis of liver 5 Yrs.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H.C. MANAUGH
H.C. MANAUGH, M. D. Chief Professional
 Address VAH, Ft. Howard, Md. Ser. _____ Date signed 4-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03622

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltoCity or town Brigies
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Glenwood Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Brigies
(If outside city or town limits, write RURAL and give nearest town)Street No. Glenwood Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry H. Lingenfelder

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 29th 1878

8. AGE: Years Months Days If less than one day

691029hrs.min.9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual occupation

Engineer

11. Industry or business

City of Balto.12. Name Henry Lingenfelder13. Birthplace Balto. Md.14. Maiden name Emma Parks

15. Birthplace " "

16. Informant Wm. W. LingenfelderAddress Glenwood Rd. Brigies, Balto. Co. Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/1/48
(month) (day) (year)Cemetery or crematory Monkland ParkLocation Parkerille Md.18. Funeral director William Cook IncAddress 1217 St. Paul St.19. 4/30 48 RW Hedrud
(Date rec'd by registrar) (Year) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28th 19. 48 at 7:00 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19. 47 to April 25 19. 48
and that I last saw him alive on April 28 19. 48

Immediate cause of death

Cerebral Embolism

DURATION

20 min.Due to ArterioscleroticDue to Cardio. vascular diseaseOther conditions 4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Joseph Micheli M. D. or otherAddress 422 Eastern Ave Date signed 4/25/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03623

Reg. Dist. No. 30

1. PLACE OF DEATH: BALTO
 County.....
 City or town.....CATONSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....MD County.....BALTO
 City or town.....CATONSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....128 MALBROOK RD
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME MARIA LORENZ

3. (b) Social Security Number

4. Sex FEM 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOW

6. (b) Name of husband or wife MARKUS LORENZ

7. Birth date of deceased (mo., day, yr.) NOV 10 - 1866 8. (c) If alive, give age..... years

8. AGE: Years 81 Months 4 Days 27 If less than one day..... hrs. min.

9. Birthplace.....GERMANY
 (Town, county, and state)

10. Usual occupation.....NONE

11. Industry or business.....

12. Name.....FREDERICK ROEGER

13. Birthplace.....GERMANY

14. Maiden name.....NOT KNOWN

15. Birthplace.....GERMANY

16. Informant.....MISS ELIZABETH LORENZ

Address.....128 MALBROOK ROAD

17. BURIAL Date thereof 4-9-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....HOLY CROSS CEM.

Location.....A. A. Co

18. Funeral director.....Bernard E. Earle

Address.....121 E West St

19. April 8 1948 9 24 Adams
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL - 6 1948 at 5:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1948 to April 6 1948 and that I last saw her alive on April 6 1948

Immediate cause of death.....Myocardial Infarction

Due to.....

Due to.....

Other conditions.....Arteriosclerosis - Hypertension - Myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due in external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....John L. Schenck

Address.....1337 S. Charles St M. D. or other 4/7/48
 Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03624

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3714 Annapolis Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County Baltimore(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 3714 Annapolis Rd.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Ellen Lowman

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed6 (b) Name of husband or wife Francis M. Lowman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 4th 18718. AGE: Years Months Days If less than one day
76 6 19 hr. min.9. Birthplace md.
(Town, county, and state)10. Usual Occupation Domestic

11. Industry or business

12. Name Mack Biden13. Birthplace md.14. Maiden Name Sussann Randall15. Birthplace md.16 (a) Informant Mary Hood(b) Address Glenburnie17 (a) Burial (b) Date thereof 4/27/48
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory London Park
Location Balto. Md.18 (a) Funeral director William Cook Inc.(b) Address 1217 St. Paul St.19 (a) APR 26 1948
(Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

29. DATE OF DEATH April 23rd 1948, at 8:45 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1943 to 4-23 1948 and that I last saw her alive on 4-23 1948

Immediate cause of death

Acute Cardiac FailureDue to Myocardial ArterioDue to Chronic Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph J. LawAddress 6796 Wadsworth Rd. Date signed 4/24/48

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45C

CERTIFICATE OF DEATH

03625

Reg. Dist. No. 191 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.
 How long in hospital or institution? 23 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard County
 City or town Glenwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I ✓

3. (a) FULL NAME

FRANK E. LYLES

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 7. Birth date of deceased (mo., day, yr.) 9-19-1890 1890 6.(c) If alive, give age _____ years
 8. AGE: Years 57 Months 6 Days 18 If less than one day _____ hrs. _____ min.

8. Birthplace Dayton, Maryland
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name William Lyles

13. Birthplace Baltimore County, Maryland

14. Maiden name Margaret Clark

15. Birthplace Baltimore County, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Ft. Howard, Maryland

17. Burial Date thereof 4-11-48
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Brown's Chapel

Location Dayton Md.

18. Funeral director W. H. Nigumbathom

Address Cleeland City Md.

19. April 9, 1948 John B. Longman
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1948 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1948 to April 7, 1948 and that I last saw him alive on April 7, 1948

Immediate cause of death SQUAMOUS CELL CARCINOMA ORAL REGION WITH PROBABLE METASTASES

DURATION

1 year

Due to _____

Due to _____

Other conditions Pneumonia, secondary to above

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. M. Burleson M.D.
 M. D. or other _____

Address VAH Fort Howard, Md. Date signed 4-8-48

RECEIVED

APR 12 1948

BUREAU V. S.

PLEASE WRITE IN UNFADING INK. Supply every item of information, especially the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03626

Evidence for change of age & BIRTH DATE shown on:

FILM NO. G 115 APR 12 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months, 21 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore -16-
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1706 Braddish Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary E. Madge

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Herbert Madge
 7. Birth date of March 3, 1887 6. (c) If alive, give age 74 years
 deceased (mo., day, yr.)
 8. AGE: Years 61 Months 11 Days 30 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business home
 12. Name John White
 13. Birthplace Unknown
 14. Maiden name Harriett (unknown)
 15. Birthplace Unknown

16. Informant Hospital records
 Address Catonsville, 28, Maryland
 17. Burial Date thereof 4/6/48
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematorium Mt. Olive
 Location Roslyn Balto. Co. Md.
 18. Funeral director William Cook Inc
 Address 1217 St. Paul St.
 19. April 5 19 48 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1948 19 _____ at 4:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 12 19 47, to April 2 19 48
 and that I last saw him alive on April 2 19 48

Immediate cause of death Acute dilatation of the stomach DURATION 20 min

Due to Intestinal ileus - postoperative 2 1/2 hrs.

Due to _____

Other conditions Arteriosclerotic heart dis. Indefinite
Hypertensive cardio-vascular "
 (Include pregnancy within 3 months of death)

Major findings of operations Herniotomy - double postoperative
epigastric hernia Date of op. 3/30/48

Autopsy results None held
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Henry C. A. Mead M.D.
Henry C. A. Mead, M. D. M. D. or other _____
 Address Catonsville, 28, Maryland Date signed 4/3/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468

03627

CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH:

County BALTO
City or town ESSEX - SOUTHERN AVE.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTO
City or town ESSEX
(If outside city or town limits, write RURAL and give nearest town)
Street No. 530 SOUTHERN AVE - 24
(If rural, give LOCATION)

2.(a) If veteran, name war WW #1

3. (a) FULL NAME

CHARLES ALBERT MANNEL

3. (b) Social Security Number

yes

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

Vivian M. MANNEL

7. Birth date of deceased (mo., day, yr.)

JUL. 16, 1896

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

51

8

29

hrs.

min.

9. Birthplace

BALTIMORE, MD
(Town, county, and state)

10. Usual occupation

ELECTRICIAN

11. Industry or business

FATHER
MOTHER

12. Name

ALBERT FREDERICK MANNEL

13. Birthplace

SAXONY, GERMANY

14. Maiden name

BETHA KOSSA

15. Birthplace

SAXONY, GERMANY

16. Informant

MRS. VIVIAN MANNEL

Address

530 SOUTHERN AVE.
BURIAL

17.

(Burial, cremation, or removal. Which?)

Date thereat

4/19/48

Cemetary or crematory

LODON PARK

Location

BALTIMORE, MD

18. Funeral director

Wm. J. Turner & Sons Inc.

Address

BALTIMORE, MD

19.

(Date rec'd by registrar)

4/20 19 48

D.W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 19 48 at 6 ¹² _P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 19 47 to April 15 19 48

and that I last saw him alive on April 15 19 48

Immediate cause of death

Cerebral hemorrhage of stomach

DURATION

2 yrs.

Due to

Due to

Other conditions

no

(Include pregnancy within 3 months of death)

Major findings of operations

no

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injury

Injured at work?

23. SIGNATURE

James F. White M.D.

M.D. or other

Address 422 Eastern Ave. Balto. 21 Date signed 4/16/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Thomas Schuriden

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94w

CERTIFICATE OF DEATH

03629

Reg. Dist. No. 38

1. PLACE OF DEATH
County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
260 Ridge Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 Ridge Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Ann McCauley

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband Samuel S. McCauley
7. Birth date of deceased (mo., day, yr.) Mar 17th 1857
6. (c) If alive, give age _____ years
8. AGE: Years 91 Months 1 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business At Home

12. Name Nathanial P. Myles

13. Birthplace Balto. Md.

14. Maiden name Mary P. Purden

15. Birthplace Balto. Md.

16. Informant Mary A. Salfner

Address 206 Ridge Ave. Towson Md.

17. Burial Date thereof 4/22/48
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Balto. Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul st.

19. 4/20 19 48 R. W. Hedrick
(Date rec'd by registrar) (Year) (Month) (Day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19th 1948 at 12⁴⁵ P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1948 to April 16th 1948

and that I last saw her alive on April 16th 1948

Immediate cause of death

Coronary Arteriosclerosis

Due to arteriosclerosis

Due to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. Hedrick M.D.

Address Towson - Md. Date signed 4/19/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The carriage is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore CountyCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? ?Hospital, institution, or street address where death occurred:
705 Franklin AvenueHow long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)Street No. 705 Franklin Avenue
(If rural, give LOCATION)2. (a) If veteran, name war ?

3. (a) FULL NAME

JOHN H. Mc CLELLAND

3. (b) Social Security Number

?

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteWidowed6. (b) Name of husband or wife Emma Mc Clelland6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) April 15, 18718. AGE: Years Months Days If less than one day
77 0 14 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Engineer Fireman11. Industry or business ?12. Name John A. Mc Clelland13. Birthplace Maryland14. Maiden name ?15. Birthplace ?16. Informant Mrs. Evelyn Berk - DaughterAddress 705 Franklin Avenue Essex17. Burial Date thereof 5 3 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Matthias CemeteryLocation O'Donnell Street Baltimore18. Funeral director Lilly & Zeiler Inc.Address 1901 Eastern Avenue Balto. 3119. May 1 1948 R. W. Hedrick
(Date received by registrar) (Year) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 th. 19 48 at 9:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 19 48 to Apr 29 19 48
and that I last saw him alive on Apr 29 19 48Immediate cause of death Coronary Thrombosis DURATION 1 dayDue to Myocardial InfarctionDue to Arterio-Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE M. A. Jacob M. D. or otherAddress 617 North St Date signed 5/1/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Jacobs

ARTISTIAN LETTER

14th May 1904

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03631

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 149 daysHospital, institution, or street address where death occurred:
V.A.H. Fort Howard, MarylandHow long in hospital or institution? 149 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State North Carolina CountyCity or town Laurinburg
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. #1
(If rural, give LOCATION)2.(a) If veteran, name war WW II ✓

3. (a) FULL NAME

LUTHER J. McDUFFIE

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 17, 1924

6. (c) If alive, give age years

8. AGE: Years Months Days It less than one day
24 0 22 hrs. min.9. Birthplace Bennettsville, N.C.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Luther J. McDuffie13. Birthplace North Carolina14. Maiden name Unknown

15. Birthplace

16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof Apr. 12, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Body shipped to Laurinburg, N.C.

Location

18. Funeral director Charles R. LawAddress 802 Madison Ave., Balto., Md.19. April 10, 48 Dawson L. Barber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 48 at 4:30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 11 19 47 to April 9 19 48
and that I last saw him alive on April 9 19 48Immediate cause of death Miliary Tuberculosis DURATION Unknown

Due to

Due to

Other conditions Sarcoidosis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

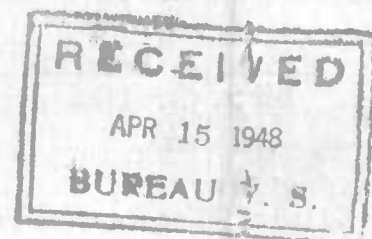
23. SIGNATURE R.W. Young M. D. or otherAddress V.A.H. FT. HOWARD, MD. Date signed 4-10-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

03632

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:

County Baltimore
 City or town Sparks
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1.25 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Sparks
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Emm Hill Rd
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Gubia Ethel McGowan

3. (b) Social Security Number

None

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed or divorced Widowed

6. (b) Name of husband or wife Leonard McGowan

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1901 6. (c) If alive, give age - years

8. AGE: Years 46 Months 7 Days 3 It less than one day hrs. min.

9. Birthplace Washington Co., Maryland
 (Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business

12. Name Wm. Griffith

13. Birthplace Wash. Co., Md.

14. Maiden name Georgianna Easterday

15. Birthplace Wash. Co., Md.

16. Informant G. Frank Enos

Address Sparks, Maryland

17. Burial Date thereof Apr. 24, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Boonsboro

Location Boonsboro, Wash. Co., Md.

18. Funeral director London M. Brooks

Address Sparks, Md.

19. Apr 12 19 48 William C Enos
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 19 48 at 10:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to April 1948
 and that I last saw her alive on 7 April 19 48

Immediate cause of death Cerebral accident DURATION 1 day

Due to Hypertension 4 yrs.

Due to Arteriosclerosis ?

Other conditions Diabetes Mellitus-Mild 1 yr

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M.D. M. D. or other

Address Cockeysville Md. Date signed 4-11-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03633

Reg. Dist. No. 47

1. PLACE OF DEATH:

County BaltimoreCity or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

1102 H Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)Street No. 1102 H St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Ellen McMillan

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John A. McMillan

7. Birth date of deceased (mo., day, yr.)

Nov. 4, 1882

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

65511

hrs.

min.

9. Birthplace

Johnstown - Cambria Co - Pennsylvania
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Jackson

13. Birthplace

Johnstown, Pa.

MOTHER

14. Maiden name

Ellen Peard

15. Birthplace

Johnstown, Pa.

18. Informant

Mrs. Caroline Smarely

Address

1102 H St., Sp. Point, Md.

17.

Burial
(Burial, cremation, or removal. Which)

Date thereof

4-19-48
(month) (day) (year)

Cemetery or crematory

Birnschiff Hill

Location

Johnstown Penna

18. Funeral director

John A. Moran

Address

3000 E. Balt. St.

19.

4/16
(Date recd by registrar)

19.

48 A.W. Hedrich
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 April 1948 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5 December 1947 to 15 April 1948and that I last saw her alive on 15 April 1948

Immediate cause of death

Carcinoma of urinary bladder

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B.W. Doreed M.D.

M. D. or other

Address 8 Liberty Parkway Date signed 15 April 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 37

03634

37

37

1. PLACE OF DEATH

County Balto.
City or town Ashland, Cockeysville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Balto.
City or town Ashland, Cockeysville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Shirley Cecelia Merryman

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 4-10-48

8. AGE: Years _____ Months _____ Days 5 hrs. _____ min. _____

9. Birthplace Cockeysville, Balto., Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Robert B. Merryman
13. Birthplace Cockeysville, Md.
14. Maiden name Sally Cecelia Clark
15. Birthplace Balto City, Md.

16. Informant Father
Address Cockeysville, Md.

17. Burial Burial Date thereof 4-16-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grace Methodist
Location Sparks

18. Funeral director F. M. Brooks
Address Sparks, Md.

19. 4/15/48 19. Wilmer C. Euser
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 4/15 19 48 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/10 19 48, to 4/15 19 48
and that I last saw him alive on 4/14 19 48

Immediate cause of death Prematurity
(7 1/2 mo. -)

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wilmer C. Euser M.D.
M. D. or other _____
Address 4 Cockeysville, Md. Date signed 4/15/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 17 1943
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170W

03635

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County.....BALTO
 City or town.....CATONSVILLE - 813 FREDR RD
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MD County.....
 City or town.....CATONSVILLE
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 27 N. Rolling Rd.
 (If rural, give LOCATION)
No

2.(a) If veteran, name war.

3. (a) FULL NAME

LOUIS FREDERICK MEYER

3. (b) Social Security Number

No

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

ELLEN WHITELY MEYER

7. Birth date of deceased (mo., day, yr.)

MAY 12, 1888

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

591110hrs.min.

9. Birthplace

BALTO. MD.

(Town, county, and state)

10. Usual occupation

REAL ESTATE BROKER

11. Industry or business

SELF

FATHER

12. Name

CHARLES H.W. MEYER

13. Birthplace

GERMANY

MOTHER

14. Maiden name

ANNA M.E. RUNGE

15. Birthplace

GERMANY

16. Informant

MR. LOUIS F. MEYER JR.

Address

4407 FERNHILL AVE

17.

(Burial, cremation, or removal, Which?)

BURIAL

Date thereof

APR 24, 1948

Cemetery or crematory

WESTERN CEM.

Location

BALTO. MD

18. Funeral director

Wm. T. TUCKER & SONS

Address

BALTO. MD

19.

(Date rec'd by registrar)

April 23 1948V.E. Harry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....4/22..... 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 24 1946, to April 22 1948
 and that I last saw him alive on April 1 1948

Immediate cause of death

Myocarditis
& Coronary Sclerosis
 Due to Coronary Occlusion - Sudden

DURATION

1 3/4 yrs.

Due to

Other conditions

Gastric Ulcer5-10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. Lloyd Johnson

M. D. or other

Address

CatonsvilleDate signed 4/23/48

RECEIVED

APR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03636

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County..... Balto.
 City or town..... Spandow Pt.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 35 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Gilles Mickey

3. (b) Social Security Number

216-10-5135

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

m

6. (b) Name of husband or wife

Minerwin

7. Birth date of deceased (mo., day, yr.)

Dec. 20 - 1899

6. (c) If alive, give age..... years

8. AGE:

48410

If less than one day

hrs.

min.

9. Birthplace

Grochland Co. Va.
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

Bethlehem Steel

FATHER

12. Name

Henry Mickey

13. Birthplace

Va

MOTHER

14. Maiden name

Martha Fife

15. Birthplace

Va

16. Informant

Minerwin Mickey

Address

812 J. St. Spandow Pt.

17.

(Burial, cremation, or removal. Which?)

Date thereof

5-4-48
(month) (day) (year)

Cemetery or crematory

Mt. Calvary

Location

C. C. Co.

18. Funeral director

Address

Samuel W. Sullivan Jr.
1011 N. Arlington Ave

19.

(Date rec'd by registrar)

May 3 1948A. J. H. H. H. H.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Balto.

City or town

Spandow Pt.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

812 J. St.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 30

19

48

21.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 20th 48 to April 30th 48and that I last saw him alive on April 30th 48

Immediate cause of death

Carcinoma of right lung

DURATION

7 months

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. H. Thomas M.D.

M. D. or other

Address

Turner St. Md.

Date signed

4/30/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03639

1. PLACE OF DEATH:
County Balto
City or town East
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
607 Franklin Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town East
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 Franklin Ave
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME
Harry Ohms

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 8. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Cath. (Parker)

6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Aug 27 - 1897

8. AGE: Years 50 Months 7 Days 25 If less than one day
.....hrs.min.

9. Birthplace 3160 E. Md
(Town, county, and state)

10. Usual occupation Job 13

11. Industry or business Job 13

12. Name Harry Ohms

13. Birthplace Balto

14. Maiden name Betty

15. Birthplace Balto

16. Informant Harry Ohms

Address 607 Franklin Ave

17. (Burial, cremation, or removal. Which?) 1-8-48 Date thereof (month) (day) (year)

Cemetery or crematory Oak Hill

Location Plot 5

18. Funeral director Ph. 5

Address 7418 Eastern Ave

19. 4-7-48 (Date rec'd by registrar) 19 48 Registrar Ph. 5

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 19 48 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 48 to April 4 19 48

and that I last saw him alive on April 4 19 48

Immediate cause of death Coronary Thrombosis

Due to Arterio Sclerotic Cardiovascular disease

Due to 1 yr.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Geo. M. Baumgardner

M. D. or other

Address Balto 6 Date signed 4-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

03640

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltimoreCity or town Ashburn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1239 Len oak Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BeltsCity or town Ashburn
(If outside city or town limits, write RURAL and give nearest town)Street No. 1239 Len oak Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Raymond Oliver

3. (b) Social Security Number

4. Sex m 5. Color or race m 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Eva Smith7. Birth date of deceased (mo., day, yr.) 7/26/1908 6.(c) If alive, give age 44 years8. AGE: Years 47 Months 7 Days 6 If less than one day
hrs. min.9. Birthplace Likiepais
(Town, county, and state)10. Usual occupation Lgmt Driver11. Industry or business Smith & Co12. Name Ray Oliver13. Birthplace Likiepais14. Maiden name Hannah Kennedy15. Birthplace Pueans16. Informant Mrs Ray OliverAddress 1239 Len oak RdDate thereof 4/5/48(Burial, cremation, or removal. Which?) 1239 Len oak RdCemetery or crematory 1239 Len oak RdLocation Chicago, Ill18. Funeral director J. J. Fisher & SonsAddress 1239 Len oak Rd19. April 19 48 G. W. Kieffer

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 48 3-45P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death..... DURATION

Coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. W. Kieffer M. D. of other Ed. H. H.Address 1010 Reedman Date signed 4-1-48

Cor Rube

Ec Tande

Swelma

RECEIVED

APR 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 48

03641

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 509 Tunbridge Rd.
(If rural, give LOCATION)2.(a) If veteran, name war WW I ✓

3. (a) FULL NAME

RAPHAEL I. O'NEILL

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, or divorced

MaleWhiteSingle6. (b) Name of husband or wife Single

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-948. AGE: Years Months Days If less than one day
53 6 2 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation unemployed

11. Industry or business

12. Name Daniel O'Neill13. Birthplace Ireland14. Maiden name Nora Hurley15. Birthplace Ireland16. Informant Clinical Records Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 4/30/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New Cathedral CemeteryLocation Baltimore, Maryland18. Funeral director Howard BlightAddress 4914 Belair Rd., Baltimore, Md.19. April 29, 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19. 48 at 7:00 Pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 21 19. 48 to April 27 19. 48and that I last saw him alive on April 27 19. 48Immediate cause of death
Cardiac dilatation & HypertrophyDue to Mitral & aortic stenosis & InsufficiencyDue to Rheumatic feverOther conditions Pulmonary edema

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. MANAUGH M.D. Chief ProfessionalAddress VAH, Ft. Howard, Md. Ser. 4-28-48

DURATION

3 Yrs.plus.

"

"

Unknown

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hours

Hospital, institution, or street address where death occurred:

Veterans Administration Hospital

How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1312 Orleans Street
(If rural, give LOCATION)

2. (a) If veteran, name war VW ✓

3. (a) FULL NAME

WILLIE PAYNE

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

—

6. (c) If alive, give age

years

7. Birth date of

deceased (mo., day, yr.)

April 20, 1895

8. AGE:

Years

52

Months

11

Days

13

If less than one day

hrs. min.

9. Birthplace

Richmond, Virginia
(Town, county, and state)

10. Usual occupation

Unemployed

11. Industry or business

FATHER
MOTHER

12. Name Willie Payne

13. Birthplace Virginia

14. Maiden name ?

15. Birthplace ?

16. Informant

Clinical Records, Vet. Adm. Hosp.
Address Fort Howard, Maryland

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director

Elroy O. Wilson
Address 1000 Brantley Ave. Balto. Md.

19.

April 6, 1948
(Date rec'd by registrar)

A. W. Hedges
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 19 48 at 1:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 2 19 48 to April 2 19 48

and that I last saw him alive on April 2 19 48

Immediate cause of death DILATATION AND HYPER-
TROPHY OF RIGHT AURICLE AND
VENTRICLE

Due to EXTREME GENERALIZED PULMONARY
EMPHYSEMA

Due to

Other conditions CHRONIC NEPHRITIS
GENERALIZED ARTERIOSCLEROSIS
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other

Address VAH, Fort Howard, Md. Date signed 4/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:

County BaltimoreCity or town Rural near Monkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Rural near Monkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 mi. east of Monkton

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Silas W. Pearce

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Minnie Pearce7. Birth date of deceased (mo., day, yr.) January 24, 18626. (c) If alive, give age 74 years

8. AGE:

Years

Months

Days

If less than one day

86223

hrs.

min.

9. Birthplace Balto. Co. Md.

(Town, county, and state)

10. Usual occupation Thresher11. Industry or business Farming12. Name Josiah S. Pearce13. Birthplace Md.14. Maiden name Elizabeth Wright15. Birthplace Md.16. Informant Mrs. Minnie PearceAddress Monkton, Ind. R. D.17. Burial Date thereof April 21, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Vernon CemeteryLocation White Hall, Md. R. D.18. Funeral director Jacob GartensteinAddress New Freedom, Pa.19. Apr 21 1948 Charles J. Pearson

(Date rec'd by registrar)

County local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1948, at 11:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 February 1947 to 18 April 1948and that I last saw him alive on 12 April 1948

Immediate cause of death

Cardiac Failure

DURATION

6 monthsDue to Arterio sclerosis15 months

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M.D.

M. D. or other

Address Cockeysville, Md. Date signed 4-19-48

RECEIVED

APR 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03644

1. PLACE OF DEATH:

County.....7040 Sollers Point Road

City or town.....Dundalk, Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth C. Pfeffer

3. (b) Social Security Number

4. Sex female	5. Color or race white	6. (a) Single, married, widowed, or divorced widowed
------------------	---------------------------	---

6. (b) Name of husband or wife.....x Fred L. Pfeffer

7. Birth date of deceased (mo., day, yr.) March 20, 1868

8. AGE: Years 80	Months	Days	If less than one day hrs. min.
---------------------	--------	------	-----------------------------------

9. Birthplace.....Germany
(Town, county, and state)

10. Usual occupation.....housewife

11. Industry or business

FATHER	12. Name.....John Graf
	13. Birthplace.....Germany

MOTHER	14. Maiden name.....Marie Cramer
	15. Birthplace.....Germany

16. Informant.....Mrs. Marie Allen - daughter
Address.....7040 Sollers Point Road17. Burial Date thereof 4/13/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or place of burial.....xxxx Loudon Park
Location.....3801 Frederick Road18. Funeral director.....Schimunek Funeral Home, Inc.
Address.....2601-3-5 E. Madison Street19. 4/13 1948 J. W. Hedrich
(Date rec'd by registrar) (month) (day) (year) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....

City or town.....Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No.....7040 Sollers Point Road
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 10 1948 at 1:15 p. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1945 to April 10 1948 and that I last saw h. OR alive on April 9 1948

Immediate cause of death.....Myocardial Regeneration after coronary artery disease

Due to.....Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Louis F. Klimes M.D.

Address.....2623 E. Monument St. Date signed 4/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

03645

1. PLACE OF DEATH:

County 7709 Crosslane RdCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md CountyCity or town Balto

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1309 Myrtle ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Marie Hill Phipps

3. (b) Social Security Number

4. Sex

Female

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Richard Phipps

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

none1901

8. AGE:

Years

Months

Days

If less than one day

47

hrs.

min.

9. Birthplace West Moreland Va

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant Georgia DouglasAddress 1309 Myrtle ave

17.

BurialDate thereof 4-25-48

Cemetery or crematory

Cemetery

Location

mt Auburn

18. Funeral director

William A Jackson

Address

916 Remond Ave

19.

4-24-48

(Date rec'd by registrar)

Dr E.E. Nishal

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 22 19 48, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-22-48 19 48 to 4-22 19 48and that I last saw her on 4-22 19 48

Immediate cause of death

congestive heart failure

DURATION

2 hrs

Due to

Hypertensive Cardio-
Renal Disease2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Dr. D.D. Caples Med. Exam.

M. D. or other

Address Reisterstown, Md. Date signed 4-24-48

RECEIVED
APR 26 1948
BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03646

47

1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 17 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County

City or town... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 711 N. Luzerne Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war... VW-II

3. (a) FULL NAME

JOSEPH FRANCIS PICH

3. (b) Social Security Number

212-10-2637

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Single

7. Birth date of

deceased (mo., day, yr.) 10-31-10

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

3759

.....hrs.

.....min.

9. Birthplace... Baltimore, Maryland

(Town, county, and state)

10. Usual occupation... Plumber

11. Industry or business

FATHER
MOTHER12. Name... John Pich13. Birthplace Austria Hungary14. Maiden name... Mary Clecta15. Birthplace Czechoslovakia16. Informant Clinical Records, Vets. Adm. Hospital

Address

Ft. Howard, Maryland

17.

Burial Date thereof 4-14-48

(Burial, cremation, or removal. Which? (month) (day) (year))

Cemetery or crematory... Holy RedeemerLocation... Baltimore, Md.

18. Funeral director

Address

Frank Brachodon
900 N. Chester St

19.

(Date rec'd by registrar)

19

4/12 48 A. W. Hedusch
Dr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 10, 1948, 10:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 24, 1948, to April 10, 1948and that I last saw him alive on April 10, 1948

Immediate cause of death

DURATION

Tuberculosis, chr. pulmonary, active Unknown

Due to

Due to

Other conditions Ulcer of tongue and left
tonsil, cause unknownUnknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R.W. Young
R.W. YOUNG, M.D.

M. D. or other

Address... V.A.H. FT. HOWARD, MD. Date signed 4-10-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

03647

1. PLACE OF DEATH:

County Baltimore Co.
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Annelle Pritchard

3. (b) Social Security Number

2. Color or race White
 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife J. Edgar Pritchard
 7. Birth date of deceased (mo., day, yr.) Feb-19-1870
 6. (c) If alive, give age..... years
 8. AGE: Years 78 Months..... Days..... If less than one day..... hrs. min.
 9. Birthplace Nashville Tenn
 (Town, county, and state)

10. Usual occupation.....
 11. Industry or business At home
 12. Name Rachel Slaby
 13. Birthplace Praque
 14. Maiden name Anna Siciro
 15. Birthplace Praque
 16. Informant Mrs Rose Sressfarn
 Address 1515 W. Market St Louisville Ky
 17. Entombment Date thereof Apr 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Green Mount Cem
 Location City
 18. Funeral director Weerick Funeral Home
 Address 2008 Orleans St
 19. 4/16 19 48
 (Date rec'd by registrar) Metron M. Smulson Registrar
Frank R. Raper

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 48 11:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 48 to April 15 19 48and that I last saw him alive on April 15 19 48Immediate cause of death Heart Accident

DURATION

4/9/48Due to O-S-C-V-Disease

Due to.....

Other conditions Hypertrophic Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

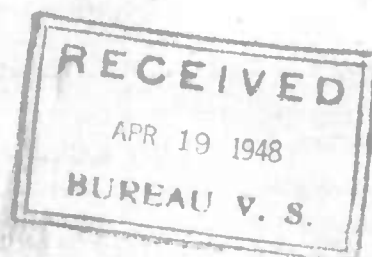
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of.....Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE M. B. Davis M.D.Address Shuadue-rv-Date signed 4/16/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03648

30

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

62 Winters Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... BaltimoreCity or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 62 Winters Lane
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Joseph William Rhodes

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>Colored</u>	<u>Divorced</u>

6. (b) Name of husband or wife.....

5. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE:	Years	Months	Days	If less than one day
<u>44</u>			 hrs. min.

9. Birthplace..... Newark, N. J.
(Town, county, and state)10. Usual occupation..... Laborer

11. Industry or business.....

FATHER 12. Name..... Carseous Rhodes13. Birthplace..... N. J.MOTHER 14. Maiden name..... Unknown15. Birthplace..... N. J.16. Informant..... Miss Maxine BriscoeAddress..... 62 Winters Lane17. Burial Date thereof..... 4-7-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Mt. Auburn Cem.Location..... Baltimore, Md.18. Funeral director..... Mrs. Frances A. HemsleyAddress..... 578 W. Biddle St.19. April 6 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 4 19 48, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-22-48 19..... to 4-4-48 19.....and that I last saw him alive on 4-4-48 19.....

Immediate cause of death.....

Acute Myocarditis 7 days

Due to.....

Due to.....

Other conditions.....

Illocolitis 3
(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... C. H. Maloney M.D.
M. D. or otherAddress..... Catonsville, Md Date signed 4/6/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03649

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs
Hospital, institution, or street address where death occurred:
1200 Summit Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1200 Summit Ave
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME Emma May Roberts 3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife Richard L Roberts
7. Birth date of deceased (mo., day, yr.) Nov. 3, 1868 6. (c) If alive, give age _____ years

8. AGE: Years 79 Months 5 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Candington, Ohio
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James B. Duncan

13. Birthplace Ohio

14. Maiden name Anna M. Blais

15. Birthplace Ohio

16. Informant Mrs. Walter E. Sample
Address 1200 Summit Ave. Catonsville

17. Burial Burial Date thereof Apr 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenwood Cemetery
Location Willard, Ohio

18. Funeral director Easton Sons
Address 608 Frederick Ave. Catonsville

19. April 8, 1948 VE. Haray
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 6, 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1948 to Apr 6, 1948 and that I last saw her alive on April 6, 1948

Immediate cause of death Cerebral Hemorrhage

Due to Atherosclerotic CVD

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

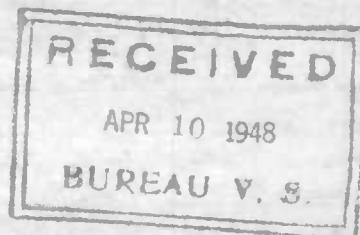
23. SIGNATURE J. P. Pound M. D. or other

Address 3325 Frederick Ave Date signed 4/7/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

03650

1. PLACE OF DEATH:

County Baileys CoCity or town Catonville Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaileysCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)Street No. 610 Edmondson ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bessie Miles Buff4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Apr 6 18778. AGE: Years 70 Months 0 Days 0 If less than one day 0 hrs. 0 min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Domestic11. Industry or business House wife12. Name William T. Miles13. Birthplace Maryland14. Maiden name Bessie Caton15. Birthplace Maryland16. Informant Mrs Edeline MilesAddress 610 Edmondson ave17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Apr 12/48
(month) (day) (year)Cemetery or crematorium Red Talent ChurchLocation Catonville Md.18. Funeral director Edw. S. Mac NellyAddress Catonville Md.19. April 12 1948 V.E. Harry
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4. 10 19 48 at 12:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6.12 19 41 to 4.10 19 48
and that I last saw h. ex alive on 4.10 19 48Immediate cause of death Coronary embolism DURATION 12 hr.Due to Carcinoma of stomach 3 mos?Due to Arteriosclerotic heart disease 7 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

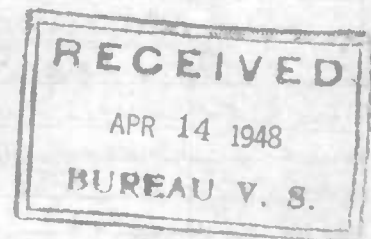
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury (Injured at work?)

23. SIGNATURE Conr E. Urban M. D. or otherAddress Catonville Md Date signed 4.10.48

2681
12
848



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03651

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 18 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 5 months, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore - 15 -
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5511 Minnoka Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Bertha Sadofsky

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife George Sadofsky 6.(c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) October 16, 1887
8. AGE: Years 60 Months 5 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name Joshua Miller
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden name Margaret Lipfert
15. Birthplace Baltimore

16. Informant Hospital records
Address Catonsville, 28, Md.
17. BURIAL Date thereof 4-12-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Western
Location Balte. Md.

18. Funeral director Harry H. Witke
Address 4101 Edmondson Ave.

19. April 12, 1948 A. W. Hedgcock
(Date) (Signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1948, at 9 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____, and that I last saw him _____ alive on _____ 19_____.
Immediate cause of death _____

Due to Exhaustion
Cardiac failure
Due to _____
Other conditions Malnutrition
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Geo. S. Kieffer Deaf Med
M. D. or other _____
Address 1010 Leidsa Date signed 4-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

03652

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BALTIMORE

City or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

HOUSE IN THE PINES 16 FORTING AVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County Balt

City or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No. 305 OAK FOREST AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HELEN M. SALTER

3. (b) Social Security Number

4. Sex

Female

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife W. H. SALTER

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 8, 1871

8. AGE:

Years

Months

Days

If less than one day

76

5

29

hrs.

min.

9. Birthplace

PENNA

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name JOHN MACNAUGHTAN

13. Birthplace SCOTLAND

14. Maiden name MARGARET J. DOUGLAS

15. Birthplace SCOTLAND

16. Informant MRS. MARY M. WOLFE

Address 305 OAK FOREST AVE

17. CREMATION Date thereof APRIL 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LOUDON PARK

Location 3001 FREDERICK AVE

18. Funeral director Henry A. Wight

Address 4101 Edmondson Ave

19. April 8, 1948 A. W. Hyndrick
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 7 19 48 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 16 19 37 to April 7 19 48

and that I last saw her alive on April 6 19 48

Immediate cause of death

Myocarditis

Emphysema

Due to Bronchiectasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Hyndrick

M. D. or other

Address 205. Bantish Date signed 4/8/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *H*

03653

1. PLACE OF DEATH:

County *Balto.*
 City or town *Dundalk*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *6 yrs.*
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Balto.*
 City or town *Dundalk*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *7921 Wise Ave*
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dora A. Schaaf

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *divorced*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *August 25-1872* 6. (c) If alive, give age _____ years

8. AGE: Years *75* Months *8* Days *0* It less than one day _____ hrs. _____ min.

9. Birthplace *Rent Co. Md.*
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name *John W. Crouch*
 13. Birthplace *Md.*
 14. Maiden name *Dorothy A. Virman*
 15. Birthplace *Md.*

16. Informant *Mrs. Dorcas De Haven*
 Address *7921 Wise Ave*

17. *Burial* Date thereof *4/28/48*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Woodlawn*
 Location *Balto.*

18. Funeral director *Philip Herwig Sons*
 Address *2024 Orleans St*

19. *4/26* *48* *D. W. Hedrick*
 (Date recd by registrar) (Year) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 26* 19 *48* *5:30* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1942* to *April 25* 19 *48* and that I last saw him alive on *April 25* 19 *48*

Immediate cause of death *Hypertension Cardiovascular - Renal Disease* DURATION *10 yrs*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? *None* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *M. B. Brown M.D.* M. D. or other

Address *Dundalk, Md.* Date signed *4/26/48*

Dr. W. Davis
3 Kniship Rd.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

03654

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH

County Baltimore CountyCity or town Spundalk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

240 - Riverside ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County BaltimoreCity or town Spundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 240 Riverside ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Charles Schelgel

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Chele Schelgel

7. Birth date of

deceased (mo., day, yr.)

January 28, 1895

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

53210

hrs.

min.

9. Birthplace

Altoma Pa.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

John T. Schelgel

13. Birthplace

Pa.

MOTHER

14. Maiden name

Mary M. Guie

15. Birthplace

Pa.

16. Informant

Chele Schelgel

Address

240 Riverside ave

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

April 9, 1948

Cemetery or crematory

St. Matthew

Location

4104 O'Donnell St.

18. Funeral director

Wendell P. Heppel

Address

312 S. Highland ave.

19.

Date rec'd by registrar

19

48Melita A. Friedman

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Coronary Occlusion

DURATION

5m

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

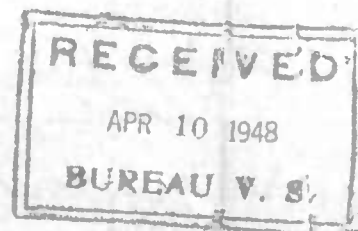
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

MB Davis
Dep. Registrar
Address Spundalk, Ind. Date signed 4/8/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03655 44

1. PLACE OF DEATH:

County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
501 F Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 F Street
(If rural, give LOCATION)
2. (a) If veteran, name war.

3. (a) FULL NAME

Ida A. Schneider

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced W.

6. (b) Name of husband or wife Philip Schneides

7. Birth date of deceased (mo., day, yr.) December 9, 1871 6. (c) If alive, give age _____ years

8. AGE: Years 76 Months 3 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Gettman

13. Birthplace Md.

14. Maiden name Carrus Scaggs

15. Birthplace Delaware

16. Informant Mrs. Anna A. Wenzel

Address 501 F St., Sparrows Point

17. Burial (burial, cremation, or removal, Which?) Burial Date thereof April 9, 1948
(month) (day) (year)

Cemetery or crematory Oak Lawn

Location 7225 Eastern Blvd.

18. Funeral director Roland L. Fisher

Address 2112 Dandale Ave.

19. April 8 - 48 D. J. Harber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from April 4 1948 to April 6 1948 and that I last saw him alive on April 6 1948

Immediate cause of death _____ DURATION _____

Coronary Occlusion 48 hrs

Due to Arteriosclerosis Ht. Dis ?

Due to _____

Other condition Diabetes Mellitus ?

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. J. Harber M.D.

Address 520 D St. Sp 17 Date signed 4.6.48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

Catonsville Convalescing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Baltimore Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1201 Washington Blvd.
 (If rural, give LOCATION)

2.(d) If veteran, name war

3. (a) FULL NAME

William Schuerholz

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife Louise

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26th 1880

8. AGE: Years Months Days If less than one day
68 1 12 hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual occupation Store Keeper11. Industry or business Self12. Name William Schuerholz13. Birthplace Germany14. Maiden name Julia Wickart15. Birthplace Baltimore Md.16. Informant Mrs Louise SchuerholzAddress 1201 Washington Blvd.17. Burial Date thereof 4/10/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Meadowridge Memorial Pk.Location Dorsey Rd.18. Funeral director John J. Cowan & SonAddress 901-03 Hollins St.19. April 9 19 48 A. W. Hefner
(To be rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 19 48 at 9:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 19 48 to April 7 19 48
 and that I last saw him alive on April 7 19 48

Immediate cause of death

Cerebral hemorrhage

DURATION

sub

Due to

Hypertension & atherosclerosis

Due to

Atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Elmer Hefner M. D. or other
 Address Elmer Hefner Date signed 4/9/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

03657

Reg. Dist. No. 4

1. PLACE OF DEATH

County Balto.
City or town Sparks Point.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

#84 Furnace, Slog pocket.
How long in hospital or institution? 2 1/2 yrs service.

3. (a) FULL NAME

Thomas Serochik or Justin Szewczuk

3. (b) Social Security Number

213-07-

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Serochik

7. Birth date of deceased (mo., day, yr.)

(Not know) 1996

8. AGE:

Years 52 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace

Russian
(Town, county, and state)

10. Usual occupation

Fareman Bethlehem Steel

11. Industry or business

? - Serochik

12. Name

Russian

13. Birthplace

not know

14. Maiden name

Russian

15. Birthplace

Mrs. Mary Serochik

16. Informant

231 Detroit Ave

17. (Burial, cremation, or removal) Which?

Burial Date thereof Apr 17-48
(month) (day) (year)

18. Cemetery or crematorium

Sacred Heart

19. Location

German Hill Road

20. Funeral director

John A Greblianskas, Jr.

21. Address

423 S. Paca St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto.

City or town 231 Detroit Ave
(If outside city or town limits, write RURAL and give nearest town)

Street No. Dundalk 22 MD
(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Apr 17 1948, at 11:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Coronary Accident

Due to.....

Beat into B.C. 4th.

Due about 9th D.O.A.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Wm. J. McNamee, M.D.

Deputy Medical Examiner

Balto. Co. Dundalk 22 MD

4/17/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03658

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
 City or town Croftonville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Croftonville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Warren Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Rosie Virginia Sheeler

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife William S. Sheeler
 7. Birth date of deceased (mo., day, yr.) Oct. 17, 1899
 6.(c) If alive, give age 68 years
 8. AGE: Years 68 Months 6 Days 8 It less than one day _____ hrs. _____ min.

9. Birthplace Balto. Co. Md.
 (Town, county, and state)
 10. Usual occupation Homemaker
 11. Industry or business _____

MOTHER FATHER
 12. Name Unknown
 13. Birthplace _____
 14. Maiden name Unknown
 15. Birthplace _____

16. Informant W. S. Sheeler
 Address Croftonville
 17. Burial Date thereof Apr. 28, 1948
 (Burial, cremation, or removal. With?) (month) (day) (year)
 Cemetery or crematory Poplar
 Location Croftonville, Md.
 18. Funeral director Sander M. Brooks
 Address Sparks, Md.
 19. 4/26 19 48 Wilmer C. Ensor
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 25 19 48 at 11:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 48 to Apr 25 19 48
 and that I last saw h. ex. alive on Apr. 25 19 48

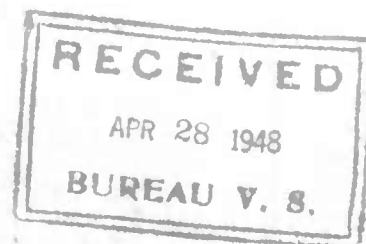
Immediate cause of death Cerebral Hemorrhage DURATION 10 days
 Due to Hypertension
 Due to Arterio sclerosis
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Wilmer C. Ensor M. D. or other _____
 Address Croftonville Md Date signed 4/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03659

Reg. Dist. No. 4X

1. PLACE OF DEATH:

County BALTO
 City or town SPARROWS Pt. Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 2102 7th Fulton Ave
 (If rural, give LOCATION)

2(a) If veteran, name war World War #2 ✓

3. (a) FULL NAME

MILTON SHELTON

3. (b) Social Security Number

4. Sex

M

5. Color or race

Bl

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Dorothy

7. Birth date of deceased (mo., day, yr.)

February 7, 1918

6. (c) If alive, give age _____ years

8. AGE:

30

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

FATHER

12. Name

Daniel Shelton

13. Birthplace

Va.

MOTHER

14. Maiden name

Fannie Logan

15. Birthplace

Va.

16. Informant

Dorothy Shelton

Address

2102 7th Fulton Ave

17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

April 13/48

Cemetery or crematory

Cres. National Cem

Location

Mrs. F. G. Elliott's Dpt.

18. Funeral director

Address

1129 N. Caroline St.

19.

(Date read by registrar)

April 12, 48A. J. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1948 at 7:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Compound Fracture of skull

DURATION

Due to

Struck on head & Steel

Due to

Door of Loading Elevator

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

_____. Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/9/48Where did injury occur Beth. Steel Co. Sp. Pt. Balt. Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) IndustryMeans of injury Struck on head with dead - Yes. Injured at work?

23. SIGNATURE

M. B. Davis M.D.Address Dept. Med. Exam. - Baltimore Md. Date signed 4/9/48

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

03660

1. PLACE OF DEATH

County

Village or City

Length of residence in city or town where death occurred

1 yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Registration Dist. No.

No.

Ward

2. FULL NAME

(a) Residence: No.

St.

Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write this word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than

1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Data deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

FATHER

13. NAME

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDERTAKER (Address)

20. FILED

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

22.

I HEREBY CERTIFY That I attended deceased from

I last saw him alive on

to have occurred on the date stated above, at

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Date of onset

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur?

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03661

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Harbor View
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balt.City or town Harbor View
(If outside city or town limits, write RURAL and give nearest town)Street No. 524 S. 48th St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alena Annice Sigel

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Hon. J. Sigel6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

Feb. 26 - 1890

8. AGE:

Years

58

Months

1

Days

26

It less than one day

hrs.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER

12. Name

Henry Amberg

13. Birthplace

Balto.

MOTHER

14. Maiden name

Anna Fleming

15. Birthplace

Germany

16. Informant

William J. Sigel

Address

524 S. 48th St.

17.

Burial
(Burial, cremation, or removal, Which?)Date thereof Apr. 26 - 78
(month) (day) (year)

Cemetary or crematory

Oak Lawn

Location

Eastern Ave. Rd

18. Funeral director

John S. Connelly

Address

418 Eastern Ave. Essex

19.

Apr. 26 - 19 48
(Date rec'd by registrar)John S. Connelly
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1948 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 10 1948 to Apr 23 1948and that I last saw him alive on Apr 22 1948

Immediate cause of death

Cerebral Thrombosis
secondary to
arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Alvan J. Stachman MD

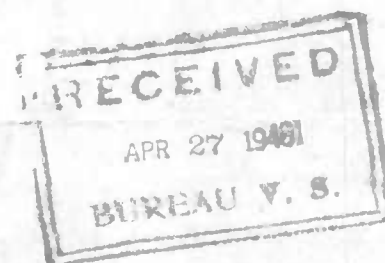
M. D. or other

Address

3026 South St

Date signed

Apr 26 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03662

Reg. Dist. No. 32

1. PLACE OF DEATH: Baltimore
 County.....
Pikesville
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Robb's Nursing Home
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....New Jersey County.....
 City or town.....Lake wood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Louisa Skidmore

3. (b) Social Security Number

4. Sex.....Female 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Widow
 6.(b) Name of husband or wife.....Benjamin Skidmore
 7. Birth date of deceased (mo., day, yr.).....? 1860 6.(c) If alive, give age..... years

8. AGE: Years.....78 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....New York, N.Y.
 (Town, county, and state)

10. Usual occupation.....Housewife

11. Industry or business.....At Home

12. Name.....William Jenkins

13. Birthplace.....Ireland

14. Maiden name.....Mary Jenkins

15. Birthplace.....Ireland

16. Informant.....Mrs. Magerum

Address.....Lutherville, Md.

17. Removal Date thereof.....April 29, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....Haven Funeral Home

Location.....Lake wood, New Jersey

18. Funeral director.....John Burns' Sons

Address.....Towson, Md.

19. Apr 29 19 48 D.E.E. nichols
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 29, 19 48, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 11, 19 46, to Apr 29, 19 48, and that I last saw her alive on April 28, 19 48.

Immediate cause of death.....Central Pneumonia 1945
arterial Hypertension ?

Due to.....Arterio Sclerosis ?

Other conditions.....Semipr

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....E.E. Nichols M. D. or other
Pikesville, Md. Date signed.....Apr 29 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03663

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Miss Cole's Nursing Home, Shadyside Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County none
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 609 Cathedral St.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

James P. Templeman

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7, 1887

8. AGE: Years 60 Months 6 Days 6 If less than one day
..... hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Teacher of languages
Baltimore City College

11. Industry or business

FATHER 12. Name Dr. James Albin Templeman

13. Birthplace Va.

MOTHER 14. Maiden name Ella Bryan

15. Birthplace Va.

16. Informant Miss Harriet Templeman

Address 3403 Fairview Ave.

17. Burial Date thereof April 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of interment Loudon Park

Location 3801 Frederick Ave., Baltimore, Md.

18. Funeral director John A. Mitchell & Sons, Inc.

Address 1900 Eutaw Place

19. 4/15 19 48 J. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 48 at 7:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46 to 13 April 19 48
and that I last saw him alive on 13 April 19 48

Immediate cause of death Empyema sears
asthmatic bronchitis

DURATION

5-10 yrs

5-10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Hedrick M. D. or other

Address 20 E. Preston St., Balto. Date signed 15 Apr 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Stemmers Run
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 weeks

Hospital, institution, or street address where death occurred:

Stemmers Run Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Balto.
(If outside city or town limits, write RURAL and give nearest town)Street No. 353 S. Bonsal Street
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

EDITH THOMAS

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Zachariah Thomas7. Birth date of deceased (mo., day, yr.) July 20th, 1883/ 1886
6. (c) If alive, give age _____ years8. AGE: Years 61 Months 164 Days 9 If less than one day
3 hrs. _____ min.9. Birthplace S. Wales
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Zachariah Jenkins13. Birthplace Wales14. Maiden name Barbara Mainwaring15. Birthplace Wales16. Informant Mr. J. ThomasAddress 353 S. Bonsal St., Balto., Md.17. burial Date thereof Apr. 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oaklawn CemeteryLocation Balto., Md.18. Funeral director Lawson Funeral HomeAddress 7401 Belair Road19. April 26 19 48 John J. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23rd, 19 48 at 7:05 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2h. 1st 19 48 to April 23 19 48
and that I last saw her alive on April 23 19 48

Immediate cause of death

DURATION

Cardio-vascular heart disease 3 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op. _____

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James F. White M.D. M. D. or other _____Address 422 Eastern Ave Date signed 4/24/48
Baltimore 4, Md

422

Eastern

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

03665

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months, 23 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 5 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
788 Franklinton Road
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Margaret Triplett (Marge A.)

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Howard J. Triplett6. (c) If alive, give age 89 years7. Birth date of deceased (mo., day, yr.) Sept 6th 1869

8. AGE:

Years

Months

Days

If less than one day

78723

hrs.

min.

9. Birthplace Carroll County, Maryland
(Town, county, and State)

10. Usual occupation

None

11. Industry or business

None12. Name Red Parrish13. Birthplace MD

14. Maiden name

Nancy

15. Birthplace

MD16. Informant Hospital recordsAddress Catonsville-28, Maryland17. Burial Date thereof 5/1/48
(Burial, cremation or removal. Which?) (month) (day) (year)Cemetery or crematory LorraineLocation Balto. Co. Md.18. Funeral director William Cook IncAddress 1217 St. Paul St.19. 4/20 19 48
(Date rec'd by registrar)Registrar MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 48 12:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....
and that I last saw him..... alive on..... 19.....

Immediate cause of death

DURATION

Acute Cardiac Failure

Due to

Cardiovascular disease
fracture left wrist
Other conditions Colon

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of April 29 48Where did injury occur? Catonsville Balto. Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HospitalMeans of injury fall out of chair Injured at work? no

23. SIGNATURE

Geoff M. Kieffer MD
Address 1010 Leeds Ave Date signed 4-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

03666

1. PLACE OF DEATH

County BaltimoreCity or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Trott

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

50 Years8 Months26 Days

It less than one day

9. Birthplace

Serial
(Town, county, and state)

10. Usual occupation

Roller Leveler operator

11. Industry or business

Bethlehem Steel Co.,

12. Name

Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 22, 1948
(month) (day) (year)Cemetery or crematory Moulton Memorial ParkLocation Taylor Ave., Baltimore County18. Funeral director Roland L. FisherAddress 2112 Dundalk Ave.19. April 21, 1948

(Date recd by registrar)

Registrar Dawson J. Harber

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)Street No. 702 F Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1948, at 4:00 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1948, to April 20, 1948and that I last saw him alive on April 19, 1948

Immediate cause of death

Coronary Occlusion

DURATION

14 days

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

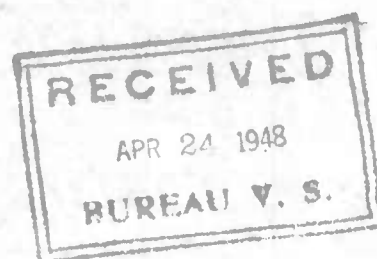
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dr. J. M. D.
M. D. or otherAddress 520 D St. S. P. 15 Date signed 4-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Registered No.

38

1. PLACE OF DEATH:

(a) Baltimore City, Maryland TOWSON
 (b) Street address 8001 York Road
 (c) Hospital or institution:
 Home at 8001 York Road
 died at home
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) 5 1/2 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore
 (c) City or town Towson
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 8001 York Road
 (If rural give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3 (a) FULL NAME

Emma Christine Vandermaast (EMMA CHRISTINE VANDERMAST)

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Ernest William Vandermaast

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

October 14, 1863

8. AGE: Years Months Days If less than one day

84 5 29 hr. min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Ferdinand Schaeke

13. Birthplace

Germany

14. Maiden Name

Mary Meinhardt

15. Birthplace

Baltimore, Maryland

16 (a) Informant

Adolph Vandermaast

16 (b) Address

8001 York Road, Towson, Md.

17 (a) Burial

(b) Date thereof 4/19/48

(Burial, cremation, or removal) (month) (day) (year)

18 (a) Cemetery or crematory

OAK LAWN CEMETERY

18 (b) Location

BALTIMORE, MARYLAND

18 (a) Funeral director

HENRY SANDER & SONS, INC.

18 (b) Address

NORTH AVE. & BROADWAY

19 (a) Date rec'd by registrar

April 17, 1948 A. W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948, at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 23, 1948, to April 15, 1948, and that I last saw her alive on April 15, 1948.

Immediate cause of death

Cardiac failure

Due to Coronary thrombosis

Due to Arterio-sclerotic Heart Disease

Other Conditions Fracture left inferior trochanteric of hip
 (Include pregnancy within 3 months of death)

Date of operation Cast applied 3-11-48

Major findings of operation:

Fracture inferior trochanteric of hip

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 3/11/48 at M

(c) Where did injury occur? Towson Md

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?

(Specify type of place)

(e) Means of injury

Fall

23. Signature Crawford N. Kishpatrick, Jr.

Address 6 East Eager St. Date signed 4-15-48

Baltimore, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03668

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore - 19-City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

3012 Ritchie Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town As in # 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EDWARD SEYMOUR VERDIER.

3. (b) Social Security Number

201-07-5784

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Carrie Verdier

7. Birth date of

deceased (mo., day, yr.)

May. 17. 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

791029

hrs.

min.

9. Birthplace

So. Mountain. Pa.
(Town, county, and state)

10. Usual occupation

Foreman

11. Industry or business

Foundry

FATHER

12. Name

Wm. Verdier

13. Birthplace

So. Mountain Pa.

MOTHER

14. Maiden name

Nagle

15. Birthplace

So Mountain Pa.

16. Informant

Curtis Verdier (Son)

Address

As in # 1

17.

(Burial, cremation, or removal. Which?)

Date thereof

7-19-48

(month) (day) (year)

Cemetery or crematory

Fairview Cem.

Location

Wrightsville Pk

18. Funeral director

Wm. J. Dickner & Sons

Address

North Pa. Aves. Baltimore

19.

(Date rec'd by registrar)

19.

4/16 48 A.W. Hedrick
Dr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 16 48 6:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 18 46 to April 16 48and that I last saw him alive on April 15 48

Immediate cause of death

Coronary occlusion. Sudden

DURATION

Due to

Hypertensive

Due to

Cardio Vascular disease 8 to 10 yrs

Other conditions

ProstatectomyFeb. 6. 1948
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Louis N. Tollen M.D.
6908 N. P+ Rd. BALTO-19 Date signed 4/16/48

22 97 transfer

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03669

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 32 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 428 W. 23rd St.
(If rural, give LOCATION)2. (a) If veteran, name war WW I

3. (a) FULL NAME

SALVATOR J. VICCHIO

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Egilda Vicchio6. (c) If alive, give age 40 years7. Birth date of deceased (mo., day, yr.) 8-6-19008. AGE: Years Months Days If less than one day
47 8 15 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Roofer

11. Industry or business

12. Name John Vicchio13. Birthplace Italy14. Maiden name Mary Detorie15. Birthplace Italy16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Md.

17. Burial Date thereof (month) (day) (year)

Cemetery or crematory New Cathedral CemeteryLocation Baltimore, Maryland18. Funeral director Wm. Cook Inc.Address St. Paul & Preston Sts., Balto., Md.19. April 23 19 48 A. W. Hedrick
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 48 at 10:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 19 48 to April 21 19 48 and that I last saw him alive on April 21 19 48Immediate cause of death Myocardial infarctionDue to Coronary Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. J. Lipin M.D. M. D. or otherAddress VAH, FT. HOWARD, MD. Date signed 4-22-48DURATION
6 Wks.
2 Wks.
plus

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03671

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Date

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 48, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 47 to April 20 19 48

and that I last saw him alive on April 19 19 48

Immediate cause of death

DURATION

Coronary occlusion

sudden

Due to

Due to

Other conditions

Arthritis, chronic alcoholism

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Elizabeth B. Sturillo, M.D.

M. D. or other

Address

Cockeysville, Md. Date signed 4-20-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03670

Reg. Dist. No. 40

1. PLACE OF DEATH

County BaltimoreCity or town Upper Falls
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County BaltimoreCity or town Upper Falls
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jacob F. Stamm

(Wann)

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 27 - 1856

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

919hrs.

min.

9. Birthplace

Harford Co. Md.
(Towp., county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Benj F. Stamm

13. Birthplace

Md.

MOTHER

14. Maiden name

Sarah Chenoweth

15. Birthplace

Md.

16. Informant

Willard J. Stamm

Address

Bradshaw Md.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof April 15 - 48
(month) (day) (year)

Cemetery or crematory

Mountain Christian Cev

Location

Joppa Md

18. Funeral director

Charles E. Arthur

Address

Towr Md.

19.

April 13 19 48
(Date rec'd by registrar)C. E. Arthur
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 48, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20 19 44, to April 17 19 48and that I last saw him alive on April 12 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

18 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Baldwin
M. D. or other _____
Address _____ Date signed 4/13/48

RECEIVED
APR 15 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03672

44

1. PLACE OF DEATH:

County Baltimore
 City or town Sparrows Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 years
 Hospital, institution, or street address where death occurred:
1216 Beachwood Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Sparrows Point
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1216 Beachwood Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edwin Warhurst

3. (b) Social Security Number

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>M</u>
6. (b) Name of husband or wife <u>Phyllis Warhurst</u>		
7. Birth date of deceased (mo., day, yr.) <u>November 20, 1886</u>		
8. AGE: Years Months Days If less than one day <u>61</u> <u>5</u> <u>0</u> hrs. min.		
9. Birthplace <u>England</u> (town, county, and state)		
10. Usual occupation <u>Machinist</u>		
11. Industry or business <u>Bethlehem Steel Co.</u>		
12. Name <u>Frederick Warhurst</u>		
13. Birthplace <u>England</u>		
14. Maiden name <u>Emily Banforth</u>		
15. Birthplace <u>England</u>		

16. Informant <u>Mrs. Phyllis Warhurst</u>		
Address <u>1216 Beachwood Rd. Sparrows Point</u>		
17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year) <u>Burial</u> <u>April 23, 1948</u>		
Cemetery or crematory <u>Moreland Memorial Park</u>		
Location <u>Taylor Ave., Baltimore, Co.</u>		
18. Funeral director <u>Poland L. Fisher</u>		
Address <u>2112 Dundalk Ave.</u>		
19. <u>April 24, 1948</u> <u>Dawson T. Harber</u> (Date read by registrar) Registrar		

MEDICAL CERTIFICATION

20. DATE OF DEATH <u>April 20</u> 19 <u>48</u> , at <u>5 a</u> M	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>April 20</u> 19 <u>48</u> , to <u>April 20</u> 19 <u>48</u> and that I last saw him alive on <u>April 20</u> 19 <u>48</u>	
Immediate cause of death	DURATION
<u>Coronary Occlusion</u>	<u>12 hrs.</u>
Due to <u>Arteriosclerosis</u>	<u>?</u>
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	
Major findings of operations	
Date of op.	
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide Date of	
Where did injury occur? (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?)	
Means of injury	Injured at work?
23. SIGNATURE <u>W. D. S. Jr.</u> M. D. or other	
Address <u>520 D St. Sp 19 Md.</u> Date Signed <u>4.21</u>	

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto
 City or town Bowleys Quarters
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto
 City or town Bowleys Quay
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Katherine Weber

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Geo Weber
 7. Birth date of deceased (mo., day, yr.) Aug 10 1878 6. (c) If alive, give age _____ years
 8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Balto
 (Town, county, and state)
 10. Usual occupation _____
 11. Industry or business At home
 12. Name William
 13. Birthplace Don't know
 14. Maiden name Don't know
 15. Birthplace _____

16. Informant Mrs Edger Clark
 Address 4205 Arizona Ave
Bethesda
 17. (Burial, cremation, or removal) Which? Burial Date thereof 4/14/48
 (month) (day) (year)
 Cemetery or crematory Schwartz Cam
 Location O'Donnell St Balto
 18. Funeral director Velvet Funeral Home
 Address 2008 Orleans
 19. 4/13 19 48 W. Gedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 48 at 11 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 48 to April 11 19 48
 and that I last saw him alive on April 11 19 48

Immediate cause of death Cerebral apoplexy DURATION 2 days

Due to arterio-sclerotic-cardiovascular disease

Due to _____
 Other conditions Chronic Nephritis 1 yr

(Include pregnancy within 3 months of death)

Major findings of operations _____
 _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE W. Baumgardner M. D. or other _____
 Address Balto 6 Date signed 4-12-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03674

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 0 yrs., 0 mos., 4 daysHospital, institution, or street address where death occurred: Mt. WilsonBranch, Md. T.B. SanatoriumHow long in hospital or institution? 0 yrs., 0 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)Street No. Mt. Wilson Sanatorium
(If rural, give LOCATION)2. (a) If veteran, name war -----

3. (a) FULL NAME

Earl T. Webster

3. (b) Social Security Number

214-10-5967

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age ----- years7. Birth date of deceased (mo., day, yr.) September 4, 19118. AGE: Years 36 Months 7 Days 7 It less than one day ----- hrs. ----- min.9. Birthplace Frederick, Maryland
(Town, county, and state)10. Usual occupation Office Clerk

11. Industry or business

12. Name Allen T. Webster13. Birthplace Frederick, Maryland14. Maiden name Ada Thomas15. Birthplace Frederick, Maryland16. Informant Earl T. WebsterAddress Mt. Wilson, Md.17. Burial Date thereof April 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olivet CemeteryLocation Frederick, Maryland18. Funeral director Etchison Funeral HomeAddress 106 E. Church St., Fred., Md.19. Apr. 11, 1948
(Date rec'd by registrar) E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1948 at 10:10 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8, 1948 to April 11, 1948and that I last saw him alive on April 11, 1948Immediate cause of death Strangulated Hernia
with Gangrene, 1 day; bilateral DURATION 1 day
pulmon. edema; gangrene of il- 1 day
eum; peritonitis. 1 dayDue to Strang. hernia; post-perfora-
ted appendectomy scar with
adhesions.Other conditions Pulmonary Tuberculosis.

(Include pregnancy within 8 months of death)

Major findings of operations Gang. ileum, about 12";
post-incision hernia Date of op. 4/10/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE B. J. Siegel M.D. M. D. or otherAddress Mt. Wilson, Md. Date signed 4/11/48

RECEIVED

APR 14 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03675

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore

City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

202 Oak Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 Oak Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

George Somerfield Whiteley, Sr.

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widower</u>
-----------------------	----------------------------------	--

8. (b) Name of husband or wife Ida E. Whiteley

7. Birth date of deceased (mo., day, yr.) July 14 - 1856
6. (c) If alive, give age _____ years

8. AGE:	Years <u>91</u>	Months <u>9</u>	Days <u>15</u>	If less than one day hrs. min.
---------	--------------------	--------------------	-------------------	--

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Auto Garage

12. Name James Whiteley

13. Birthplace Baltimore, Md.

14. Maiden name Julia A. Shipley

15. Birthplace Baltimore, Md.

16. Informant Mrs. George S. Whiteley, Jr.

Address 202 Oak Avenue, Pikesville, Md.

17. Burial Date thereof May 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18. Funeral director Frank H. Newell

Address Pikesville-8, Md.

19. 5 - 1 48 Dr E E Michael
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1948 at 8:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1948, to April 29, 1948

and that I last saw him alive on April 25, 1948

Immediate cause of death

DURATION

Arterio Sclerosis

2

Due to

Due to

Other conditions Senility

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr E E Michael M. D. or other

Address Pikesville, Md. Date signed 5/1/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

LOCAL BOARD OF HEALTH

AMERICAN LEGATION



PLEASE WRITE PLAINLY IN INK. Supply every item of information. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03676

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years 16 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 13 years 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Spring Lane
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW

3. (a) FULL NAME

Crofton Whitter

3. (b) Social Security Number

100

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Mary Gunther Whitter
deceased 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 13, 1874
 8. AGE: Years 74 Months 0 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore
 (Town, county, and state)
 10. Usual occupation Electrician
 11. Industry or business Electrical

12. Name William Whitter
 13. Birthplace Bermuda
 14. Maiden name Amelia Gaddes
 15. Birthplace Baltimore, Md.

16. Informant Hospital Records
 Address Spring Grove State Hospital
 17. Burial Date thereof 5/1/48
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Not Known
 Location Baltimore, Md
 18. Funeral director William J. Taylor
 Address 1219 1/2 Paul St
 19. 4/30 19 48 AW Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 48 at 6.15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 13, 19 33, to April 29 19 48
 and that I last saw him alive on April 29 19 48

Immediate cause of death

Right Lobar Pneumonia

DURATION

12 hrsDue to Generalized Atheromatosisindefinite

Due to Arteriosclerotic Heart Disease
Glomerular Nephritis

indefiniteindefinite

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results As Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Struck Injured at work? _____23. SIGNATURE Dr. I. Tuerk M.D.

M. D. or other

Address Catonsville 28, Md. Date signed 4-29-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03677

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town 740 Charming Cross Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Baltimore
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 740 Charming Cross Road
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Carrie Johnson Wiley

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife Robert L. Wiley
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Oct 8 1871
8. AGE: Years 76 Months 5 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Madonna Harford Co md
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Nicholas Watt
13. Birthplace Harford Co md
14. Maiden name Rebecca Cairnes
15. Birthplace Harford Co md

16. Informant M. J. Wiley
Address White Hall md

17. Burial Date thereof Apr 24 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel

Location Madonna Harford Co md

18. Funeral director Charles C. Hunt

Address Garrettsville md

19. April 22 48 19 48 V. E. Harry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 48 at 9:40 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 48 to April 22 19 48
and that I last saw him alive on April 21 19 48

Immediate cause of death Carcinoma of Pancreas, c
General Metastases DURATION Jan 1947

Due to _____
Due to _____

Other conditions Cerebral Hemorrhage July 18 48
Diabetes Mellitus 26 years
Malnutrition 1937/48

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

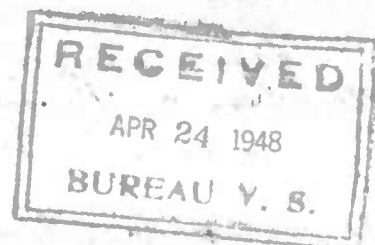
23. SIGNATURE Eliot W. Johnson M. D. or other _____

Address 3432 Duluth Ave Date signed 4/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
 County..... **Baltimore**
 City or town..... **Loreley**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Old Philadelphia Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Maryland** County..... **Baltimore**
 City or town..... **Loreley**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **Old Philadelphia Road**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Margaret Williams

3. (b) Social Security Number

4. Sex..... **Female** 5. Color or race..... **Colored** 6. (a) Single, married, widowed, or divorced..... **Married**
 6. (b) Name of husband or wife..... **Dennis Williams**
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... **November 22, 1896**
 8. AGE: Years..... **51** Months..... **5** Days..... If less than one day..... hrs. min.

9. Birthplace..... **Harford Co., Md.**
 (Town, county, and state)
 10. Usual occupation..... **Housewife**
 11. Industry or business.....
 12. Name..... **Edward Bell**
 13. Birthplace..... **Md.**
 14. Maiden name..... **Josephine Hill**
 15. Birthplace..... **Md.**

16. Informant..... **Mr. Dennis Williams**
 Address..... **Loreley, Balto., Co., Md.**
 17. Burial..... Date thereof..... **4-22, 1948**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Clark's Chapel**
 Location..... **Clark's Chapel, Harford Co., Md.**
 18. Funeral director..... **Mrs. France A. Hemsley**
 Address..... **578 W. Biddle St.**

19. **April 22** 19 **48** **A. W. Hedrick**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **April 18** 19 **48** at **6:35P** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **April 15** 19 **48** to **April 18** 19 **48** and that I last saw him/her alive on **April 15** 19 **48**

Immediate cause of death..... **Coronary Occlusion**
 Due to..... **Myocardial Infarction** 5 yrs
 Disease
 Due to.....
 Other conditions..... **Rheumatoid Arthritis**
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE..... **Joseph B. Hedrick**
 M. D. or other
 Address..... **St. Michaels Rd** Date signed..... **4-19-48**

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months 20 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 9 months 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town Baltimore-17
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1322 Linden Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Bert Wilson

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Malissa Ferguson

7. Birth date of deceased (mo., day, yr.) July 10, 1905 6. (c) If alive, give age 41 years

8. AGE: Years 42 Months 9 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business Paint

12. Name Bert Wilson

13. Birthplace Virginia

14. Maiden name Nannie Wagoner

15. Birthplace Virginia

16. Informant Hospital records

Address Baltimore-28, Maryland

17. Burial Date thereof 7/10/48
(Burial, cremation or removal Which?) (month) (day) (year)

Cemetery or crematory _____

Location Lebanon, Va

18. Funeral director John O Mitchell Wood Ave

Address 11900 Eutaw Place

19. April 16 19 48 V E Harry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 48 at 2:05 p.m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 19 47, to April 15 19 48

and that I last saw him alive on April 15 19 48

Immediate cause of death _____ DURATION

Acute myocardial insufficiency 4 hours

Pulmonary oedema - acute 2 hours

Due to Chronic coronary sclerosis Indefinite

Due to Arteriosclerotic heart disease "

Other conditions Tuberculosis - fibro-calcific "

right apex
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____

Address Catonsville-28, Md. Date signed 4-15-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAIN INK. Supply every item of information with UNFADING INK. is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

03680

1. PLACE OF DEATH:

County Baltimore
 City or town Towson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
412 Delaware Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Towson
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 412 Delaware Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

RUTH COCKEY WOODWARD

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Samuel K. Woodward
Deceased 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 11, 1874
 8. AGE: Years 73 Months 9 Days 3 If less than one day _____ hrs. _____ min.
 9. Birthplace Jacksonville, Balto. Co., Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business At Home
 12. Name Elisha Jackson
 13. Birthplace Maryland
 14. Maiden name Pryssilla Lynch
 15. Birthplace Maryland

16. Informant Raymond Woodward
 Address Providence, Maryland
 17. Burial Date thereof April 17, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Prospect Hill Cemetery
 Location Towson, Maryland
 18. Funeral director John Burns & Sons
 Address Towson, Maryland

19. April 17, 1948 G. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 19 48 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from near 15 19 48 to April 12 19 48
 and that I last saw her alive on April 12 19 48

Immediate cause of death _____

DURATION

Coronary Occlusion 7 wks.
 Due to arterio-sclerosis and
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John Burns & Sons M.D.Address Towson, Md M. D. or other _____Date signed 4/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.